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No. 89-____

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

HOODKROFT CONVALESCENT CENTER, INC., *et al.*,
Petitioners,

v.

STATE OF NEW HAMPSHIRE,
DIVISION OF HUMAN SERVICES, *et al.*,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

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QUESTION PRESENTED

The federal Medicaid statute requires the States to set "rates . . . reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 U.S.C. § 1396a(a)(13)(A). Pursuant to this provision, the State of New Hampshire's Medicaid plan provides reimbursement for the wear and tear on buildings and equipment, that is, depreciation. Unlike most other States, however, New Hampshire has interpreted its regulations to require recapture of all prior reimbursement for depreciation upon sale of the asset at a gain, even if the "gain" results from inflation, market conditions, or other factors not related to a lack of actual wear and tear.

The question presented here is whether the United States Court of Appeals for the First Circuit erred in holding—in conflict with the decision of United States Court of Appeals for the Eleventh Circuit—that New Hampshire's interpretation of its regulations to provide for such recapture is reasonable, in view of the requirement of the Medicaid Act that the States must reimburse nursing home operators for "the costs which must be incurred by efficiently and economically operated facilities," where application of the regulations in this way results in a denial of reimbursement for actual consumption of capital assets placed in service in the Medicaid program.

LIST OF PARTIES AND RULE 28.1 LIST

The petitioners, appellants in the Court of Appeals, are Hoodkroft Convalescent Center, Inc., and its sole shareholder, Norman Turcotte. Hoodkroft Convalescent Center, Inc., has no parent corporation, subsidiaries, or affiliates.

The respondents, appellees in the Court of Appeals, are the State of New Hampshire, Division of Human Services, and Louis Sullivan, Secretary of the United States Department of Health and Human Services.

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v.

STATE OF NEW HAMPSHIRE,
DIVISION OF HUMAN SERVICES, *et al.*,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

Petitioners Hoodkroft Convalescent Center, Inc. and Norman Turcotte respectfully pray that this Court issue a writ of certiorari to review the judgment of the United States Court of Appeals for the First Circuit entered in the proceedings entitled *Hoodkroft Convalescent Center, Inc., et al. v. State of New Hampshire, Division of Human Services, et al.*, July 14, 1989.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the First Circuit is reported at 879 F.2d 968 (CA1 1989), and is reprinted in the Appendix, at 1a-15a. The judgment of the Court of Appeals, entered July 14, 1989, is reprinted in the Appendix, at 27a.

The opinion of the United States District Court for the District of New Hampshire is reported at 701 F. Supp.

17 (N.H. 1988), and is reprinted in the Appendix, at 16a-26a.

JURISDICTION

The Court of Appeals for the First Circuit entered its judgment July 14, 1989. This Petition is filed within ninety days of the entry of that judgment. *See* 28 U.S.C. § 2101(c). This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

The statutes and regulations cited below are involved. Pursuant to Rule 21.1(f) of the Rules of the Supreme Court, the texts of these statutes and regulations are set out in the Appendix at 28a-73a.

42 U.S.C. § 1396a(a)(13)(A)

N.H. He-W 504.18(p)(6)b

N.H. Medical Assistance Manual § 9999.7b

Medicare Provider Reimbursement Manual-1 § 132

42 C.F.R. § 405.415

STATEMENT OF THE CASE

Petitioner Hoodkroft Convalescent Center, Inc. operated a nursing home located in Derry, New Hampshire. Petitioner Turcotte is the sole shareholder in Hoodkroft, and personally owned the nursing facility operated by Hoodkroft, which Turcotte leased to Hoodkroft.

In 1974, Hoodkroft Convalescent Center, Inc. began participating in the Medicaid program administered by the State of New Hampshire, Division of Human Services. Pursuant to various State and federal statutes and regulations (discussed below), the State reimbursed Hoodkroft for care rendered by Hoodkroft to eligible patients at a *per diem* rate set by the State.

The per diem rate included a component reimbursing Hoodkroft for the depreciation of Hoodkroft's capital as-

sets. During the period at issue in this case, from July 1, 1977, to July 31, 1985, Hoodkroft claimed $321,902.00 in depreciation as an allowable cost. The State reimbursed Hoodkroft for $173,089.00 of that amount.

On July 31, 1985, Hoodkroft and Turcotte sold the equipment, land, and buildings used in operating its nursing home to a third-party for $3,000,000.00. In this transaction, Hoodkroft realized a gain on its assets of $2,325,081.00. The State then sought recapture of the total amount it had paid Hoodkroft in depreciation, $173,089.00. The State interpreted its regulations to require recapture of all reimbursement paid for depreciation, to the extent of the gain on sale, without regard to whether the gain on sale resulted from depreciation in excess of actual wear and tear, or from other factors, for example, inflation or market conditions.

The State sought reimbursement pursuant to the regulations it had established under the Medicaid program. Congress established that program to provide for sharing by the federal and State governments of the costs of providing medical care to low-income people. The program is set out in Title XIX of the Social Security Act, 42 U.S.C. § 1396, *et seq.* The statute requires each State that wishes to participate in the Medicaid program to submit a plan for medical assistance that meets certain criteria, 42 U.S.C. § 1396a, and provides that upon approval of the plan by the Secretary of Health and Human Services, the State and federal governments will share in the cost. The State administers the plan. 42 U.S.C. § 1396b.

Among the criteria that the statute requires each State plan to meet is the requirement that the plan reimburse the medical care provider for the actual cost of providing care efficiently and economically. The statute states, insofar as is pertinent here:

"(a) Contents

"A State plan for medical assistance must—

* * * *

"(13) provide—

"(A) for payment . . . of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; . . . ." 42 U.S.C. § 1396a(a)(13)(A), Appendix To Petition For Writ of Certiorari ("App.") at 28a-29a.

The New Hampshire Medicaid plan, approved by the Secretary of Health and Human Services, is administered by the State's Division of Human Services. N.H. Rev. Stat. Ann. 161:2 VI. That agency has promulgated rules defining what costs will be reimbursed under the State's medicaid plan as "reasonable, necessary, and related to patient care." N.H. Rule He-W 504.18(p), App. at 30a. Among the "allowable costs" recognized by the State is "an appropriate allowance for depreciation of equipment and property." N.H. Rule He-W 504.18(p)(6)b.1, App. at 30a. The rule also provides:

"III. Sales of depreciable assets at a gain

"If any property is sold at a gain for which Medicaid reimbursement for depreciation has

> been received, such gain shall be subject to recapture. The extent to which any such reimbursement is recaptured shall be determined by the Bureau of Provider Audits and Rate Setting." N.H. Rule He-W 504.18(p)(6)b.1.III, App. at 31a.

The Bureau of Provider Audits and Rate Setting referred to in the regulation in turn relies upon the Division of Human Services Medical Assistance Manual for calculating recapture. This Manual also provides that "an appropriate allowance for depreciation of equipment and property is an 'allowable cost,'" N. H. Medical Assistance Manual § 9999.7b(1), App. at 32a, and further states:

> "(d) *Sales of depreciable assets at a gain*
>
> "If any property is sold at a gain for which Medicaid reimbursement for depreciation has been received, such gain shall be subject to recapture. The extent to which any such reimbursement is recaptured is calculated based on HIM-15 Section 132, Gains and Losses on Depreciable Assets (Excluding Casualty Losses)." N.H. Medical Assistance Manual § 9999.7b(1)(d), App. at 34a.

The "HIM-15 Section 132" referred to by the Medicaid Assistance Manual is the federal *Medicare* Provider Reimbursement Manual which implements the Medicare regulation analogous to the State Medicaid regulation here at issue, 42 U.S.C. § 405.415, App. at 56a-73a.[1]

The federal Medicare program was established by Title XVIII of the Social Security Act, 42 U.S.C. § 1395, *et seq.* That statute—like the Medicaid Act—requires reimbursement payments to providers for the lesser of their charges or reasonable incurred costs, 42 U.S.C. § 1395f

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[1] The federal regulation was re-numbered in 1987 as 42 C.F.R. § 413.134. No substantive change was made in the regulation. The Court of Appeals opinion in this case used the old numbering system. For the sake of convenience, this petition also does so.

(b) (1), and defines reasonable cost as "the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v) (1) (A).

Federal Medicare regulations, in turn, provide that "an appropriate allowance for depreciation on buildings and equipment used in the provision of patient care is an allowable cost" for reimbursement. 42 C.F.R. § 405.415 (a), App. at 56a. The Medicare regulation provides for recapture in the same way New Hampshire's Medicaid regulation does. It states, in part:

> "(f) *Gains and losses on disposal of assets.* (1) *General.* Depreciable assets may be disposed of through sale, scrapping, trade-in, exchange, demolition, abandonment, condemnation, fire, theft, or other casualty. If disposal of a depreciable asset results in a gain or loss, an adjustment is necessary in the provider's allowable cost. The amount of a gain included in the determination of allowable cost shall be limited to the amount of depreciation previously included in the Medicare allowable costs." 42 C.F.R. § 405.415(f), App. at 63a.

Finally, the Provider Reimbursement Manual promulgated by HHS to govern Medicare reimbursement, at § 132, provides:

> "C. The net depreciation adjustment on the disposition of depreciable assets includes: (1) the amount of the gain or loss, (2) indirectly, the depreciation adjustment on those assets acquired prior to entrance into the program, and (3) depreciation taken in excess of straight-line depreciation for a provider that disposes of all of its depreciable assets and is subject to recovery of accelerated depreciation in accordance with the requirements described in § 136. With respect to a gain on disposition, *the net depreciation adjustment will be limited to the amount of depreciation accumulated for that asset under the*

program." Medicare Provider Reimbursement Manual-1, § 132C, App. at 39a-40a (emphasis in original).

This section of the Medicare Provider Reimbursement Manual is the provision incorporated by N.H. Medical Assistance Manual § 9999.7b(1)(d). New Hampshire's Medicaid plan thus incorporates the federal rules and regulations governing recapture of depreciation under Medicare.

After Hoodkroft sold its assets, the New Hampshire Division of Human Services, Bureau of Provider Audits, interpreted the State's regulations to require reimbursement of the entire $173,089.00 the State had paid Hoodkroft in depreciation. Petitioner appealed, and the State officer hearing the appeal stayed further administrative proceedings pending judicial consideration of the rules governing recapture.

Hoodkroft then filed an action for declaratory relief in the Superior Court of Rockingham County, New Hampshire, against the Division of Human Services, alleging that the State's attempt to recapture the depreciation payments contravened the Medicaid statute's mandate that the State reimburse Hoodkroft's reasonable costs. The Division of Human Services removed the action to the United States District Court for the District of New Hampshire pursuant to 28 U.S.C. § 1441, *et seq.*, and moved to join the Secretary of Health and Human Services as a party-defendant.[2] (Petitioner Hoodkroft subsequently filed an amended complaint adding petitioner Turcotte as a party-plaintiff.)

The parties filed cross-motions for summary judgment. Both the State and the Secretary of Health and Human Services argued, *ipse dixit*, that when a provider sells a depreciable asset for a gain over book value, any depreciation paid in the past, to the extent of the gain on

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[2] The Secretary, then Dr. Otis Bowen, now Dr. Louis Sullivan, did not oppose the Division's motion.

sale, was not a cost actually incurred, and therefore need not be reimbursed pursuant to 42 U.S.C. § 1396a(a)(13)(A).

Hoodkroft and Turcotte contended that despite any increase in market value of their capital assets from 1977 to 1985, those assets had suffered actual wear and tear that had reduced the assets' value below what the assets would have been worth if the assets had not been used. Any difference between book value and the sales price, petitioners argued, resulted from inflation or market forces. Accordingly, petitioners argued that New Hampshire's interpretation of its recapture regulations violated § 1396a(a)(13)(A), because it deprived petitioners of the "costs" represented by the actual depreciation of capital assets expended in the Medicaid program. At the least, petitioners argued, New Hampshire had to interpret its rules to exempt gains that providers could prove resulted from inflation or other market factors rather than from lack of actual wear and tear.

Without conducting an evidential hearing, the District Court granted summary judgment for respondents. *Hoodkroft Convalescent Center, Inc. v. State of New Hampshire, Division of Human Services*, 701 F. Supp. 17 (N.H. 1988) (Devine, C.J.), App. at 16a-26a. The District Court found that petitioners "are correct in noting that their capital assets suffered wear and tear," 701 F. Supp. at 20, App. at 20a; but the District Court also found, inconsistently, that "the Secretary [of Health and Human Services] and the State of New Hampshire have reasonably concluded that a facility which has been sold at a gain has not actually incurred the cost of depreciation." *Ibid.*, App. at 20a. The District Court opined that depreciation was to some extent an artificial concept, and that it would not substitute the Court's notion of proper accounting for that of the regulators. *Ibid.*, App. at 20a.

The District Court supported its holding by reference to an amendment to the Medicare Act passed in 1984. That amendment, the District Court observed, required the

Secretary of Health and Human Services to continue recapture of depreciation under the Medicare Act pursuant to then-existing regulations, thus impliedly approving those regulations. *Id.* at 20-21, App. at 20a-21a.[3]

Petitioners timely appealed. The Court of Appeals for the First Circuit affirmed. 879 F.2d 968 (CA1 1989), App. 1a-15a, 27a.[4]

The Court of Appeals began its discussion of this issue by noting that the Court of Appeals for the Eleventh Circuit had "accepted a version of [petitioners'] argument" in *Mercy Community Hospital v. Heckler*, 781 F.2d 1552 (CA11 1986), a case holding that the federal Medicare recapture regulation, 42 C.F.R. § 405.415(f)(1), violated the Medicare statute's reimbursement requirement. 879 F.2d at 972, App. at 9a. The Court of Appeals for the First Circuit characterized the Eleventh Circuit's ruling as follows:

> "The [Eleventh Circuit] reasoned that, because the recapture rule fails to distinguish between gains that merely reflect 'inflation or market supply and demand characteristics,' and gains that reflect a lack of depreciation, it 'deprives providers of reimbursements made for the consumption of their assets without regard to whether those payments in fact overcompensated the provider for reasonable costs acually incurred.'" 879 F.2d at 972, App. at 9a, *quoting Mercy Community Hospital, supra*, 781 F.2d at 1558.

The Court of Appeals next proceeded to reject the Eleventh Circuit's analysis, finding that "the state and federal recapture rules represent a reasonable, and there-

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[3] Petitioners raised several other issues in the District Court, none of which they assert now. 701 F. Supp. at 21-23, App. at 21a-26a.

[4] Judge Breyer wrote the Court's opinion, which Judge Bownes and Judge Gray, a Senior District Judge of the Central District of California, joined.

fore lawful, interpretation of the Medicare statute." 897 F.2d at 972, App. at 9a.[5]

The Court rested its holding on its view that depreciation was merely an artificial construct, an "accounting fact," not "a physical fact [or] an economic fact," representing " 'not the actual changes in value from year to year but a stylized downward trend.' " 879 F.2d at 973, App. at 10a, *quoting* J. Bonbright, A. Danielson & D. Kamerschen, *Principles of Public Utility Rates*, at 276 (1988).

The Court analogized the recapture rule to certain practices under the Internal Revenue Code and in the setting of public utility rates, which measure gain "as nominal dollar profit upon resale of property, and disregar[d] the possibility that a nominal gain upon sale may be due only to inflation." *Id.* at 973, App. at 11a.

The Court of Appeals recognized that "the main reason that utility regulators, and presumably Medicaid administrators, use historical, nominal dollars to calculate depreciation and other costs is administrative efficiency." *Id.* at 974, App. at 14a. Actually to take into account true rates of wear and tear, inflation, and special market factors "would pose formidable administrative difficulties," difficulties that (in the Court of Appeals' eyes) justified the regulators in ignoring such reality-based factors entirely. *Ibid.*, App. at 14a.

The Court also concluded that New Hampshire's system was not "seriously unfair," *id.* at 975, App. at 14a, because investors knew the rules in advance.

> "New Hampshire has simply fashioned a reimbursement system that is indifferent as to whether the

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[5] In rejecting *Mercy Community Hospital*, the Court of Appeals followed the holdings in two other decisions, *Stewards Foundation v. United States*, 654 F.2d 28 (Ct. Cl. 1981), and *Professional Medical Care Home, Inc. v. Harris*, 644 F.2d 589 (CA7 1980).

dollars that reimburse come from inflation, special economic conditions, less-than-expected wear and tear, or any other source. Although there are obvious fairness problems that arise whenever a tax, regulatory, or cost reimbursement system is indifferent to inflation in this way, if the parties know in advance that the rules treat them somewhat like investors in bonds, we cannot say the unfairness is great enough to make the depreciation recapture rule unreasonable." *Id.* at 975, App. at 15a.[6]

REASONS FOR GRANTING THE WRIT

The Decision Below Conflicts With The Medicaid Act And With The Decision Of The United States Court of Appeals For The Eleventh Circuit

The Court of Appeals' decision in this case ignores economic reality, contravenes the mandate of the Medicaid Act, and conflicts with the decision of the Court of Appeals for the Eleventh Circuit in *Mercy Community Hospital.* The interpretation and administration of the Medicaid statute involve a vital federal interest. This Court should exercise its discretion to review the important and unsettled federal question this Petition presents. Rule 17.1, Rules of the Supreme Court.

The Medicaid statute requires that if a State wishes to participate in the program, it must establish a plan that reimburses provider costs for efficiently and economically operated facilities. Among the costs incurred by operators of facilities providing medical assistance under Medicaid is the consumption of long-term assets, such as buildings and equipment.

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[6] The Court of Appeals also relied on the broad discretion it believed the federal statute gave the State to establish recapture rules. The Court noted that the 1984 amendment to the Medicare Act, relied upon by the District Court, supported the view that the Secretary's Medicare rules—and thus the cognate New Hampshire Medicaid rules—were reasonable. 879 F.2d at 972, App. at 9a-10a.

No one can gainsay that providers actually use up such long-term assets in providing Medicaid services. A building, a boiler, medical equipment—all capital assets—are in fact consumed to a greater or lesser extent after they are placed in service. Indeed, in this case the District Court found as a fact that petitioners' "capital assets suffered wear and tear." 701 F. Supp. at 20, App. at 20a.

New Hampshire—like virtually every other State—recognizes that the consumption of long-term assets creates "costs" which must be incurred by efficient and economic providers, and that such costs must be reimbursed by State Medicaid plans. *See* notes 9-11, below. Where New Hampshire goes astray is in its interpretation of its regulations to require recapture of such depreciation payments to the extent of a gain realized at sale of the asset, regardless whether the gain resulted from lack of actual wear and tear, or from inflation or other market factors, for example, demographic changes, shortages, or the good-will built up over time by the provider.

Petitioners concede that the sale of unconsumed capital assets at a price in excess of depreciated book value *could* result from the fact the provider did not actually expend the asset at the rate at which the provider received depreciation. For example, an error in estimating useful life or the rate of consumption could cause an overpayment. In such cases, recapture would be proper.

But in other cases, factors not related to lack of actual wear and tear will account for the gain on sale. Inflation will increase the dollar value of an asset over time, even as the asset is being consumed in service. Over a period of years, this inflationary increase could be significant: for example, from 1977 through 1985, the period of time at issue in this case, the consumer price index rose at an average rate of 7.37% per year, increasing the cost of consumer goods by 88.5% during that nine-year period. U.S. Bureau of the Census, *Statis-*

tical Abstract of the United States: 1989, at 472 (109th ed.)

An increase in market demand may also increase value while the asset is being expended. A growth in the surrounding Medicaid-eligible population, a shortage of comparable goods in the provider's market, or good-will the provider built up over time all could increase the value of the provider's capital assets, even though those assets were being consumed at the rate assumed by the depreciation schedule.

Recapture upon a gain at sale of depreciation that resulted from actual wear and tear thus denies the provider reimbursement for a cost it actually incurred, in violation of § 1396a(a)(13)(A). The example used by the Court of Appeals illustrates the problem:

> "[A]ssume that a nursing home bought equipment with a 30 year expected useful life for $300,000. It would depreciate the equipment for 30 years at a rate of $10,000 per year. Suppose that after 10 years, when the depreciated value of the equipment was only $200,000, the facility sold it for $600,000. The equipment, says the facility, is still used up and in bad condition; the high price reflects only inflation. Indeed, the facility says, the same equipment in perfect condition would sell, in Year Ten, for $900,000 (since prices between Year One and Year Ten have trebled due to inflation). So, in its view, the wear and tear deprived it of an additional $300,000 profit. Yet the recapture rule would take back the $100,000 the facility received for depreciation between Year One and Year Ten." 879 F.2d at 972, App. at 8a.

This example shows that the recapture policy not only fails to compensate the provider for actual costs, but also that the depreciation payments actually made may significantly under-compensate the provider for the use of its assets, the value of which increased each year solely

because of inflation. This is because straight-line depreciation allowances assume that the asset's value does not increase each year. If the asset's market value in fact did grow even as the asset was consumed in use, however, the actual cost to the Medicaid provider of placing the asset in service would exceed the depreciation allowance.

The New Hampshire policy thus fails to meet the statutory mandate of 42 U.S.C. § 1396a(a)(13)(A), that the States *"must"* provide for reimbursement at rates which the State establishes as "reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated facilities." The State's interpretation of its regulation is thus not "reasonably related to the purposes of the enabling legislation." *Mourning v. Family Publications Service*, 411 U.S. 356, 369 (1973).

The Court of Appeals for the Eleventh Circuit reached this conclusion in *Mercy Community Hospital v. Heckler*, *supra*. That case involved the *Medicare* regulations requiring recapture, 42 C.F.R. § 405.415, the very regulation which New Hampshire has incorporated into the Medicaid reimbursement scheme at issue in this case. In *Mercy Community Hospital*, the provider sold its capital assets for a price well in excess of book value. 781 F.2d at 1552. The Secretary of Health and Human Services determined that, under § 405.415, she could recapture all the depreciation paid the provider to the extent of the excess of the selling price over book value. *Ibid.* The provider argued that the Secretary's interpretation of § 405.415 was unreasonable in view of the Medicare Act's mandate that the Secretary establish regulations to provide for reimbursement of the lesser of the provider's charges or the reasonable cost of providing services. *Id.* at 1552-1553.

After the District Court found for the Secretary, the Court of Appeals reversed. It concluded that the "sale of the unconsumed remainder of the depreciable assets at

a price in excess of their depreciated book value does not necessarily imply, as the Secretary seems to argue, that the provider did not actually incur some portion of the costs it was reimbursed for the consumption of the asset before it was sold." *Id.* at 1557. The Court conceded that, in some cases, the excess of the sales price over book value might result from "over-depreciation," that is, wear and tear at a rate less than that assumed by the rate of depreciation, and that in such cases recapture of depreciation payments would be appropriate under § 405. 415. *Ibid.* But the Court found that in many cases, "a gain on the sale of depreciable assets might result from other factors . . . that cannot possibly be said to suggest that the provider was overcompensated for consumption that occurred or compensated for consumption that did not occur." *Ibid.* The Court of Appeals said:

> "An increase in the demand for the provider's assets, for example, may cause the market value of the unconsumed remainder of the provider's assets to increase, although they are still being consumed at precisely the rate used to calculate the depreciation allowances that are paid under the Medicare program. The monetary value of depreciable assets may also increase as the assets are being consumed simply because of the effect on market values of inflation. An increase in the market value of those assets due to changing market conditions or inflation in no way suggests, however, that depreciation allowances claimed for the consumption of the assets were excessive." *Ibid.*

The Court of Appeals found the Secretary's interpretation of § 405.415 therefore to be unreasonable, because the Secretary recognized no distinction between gains on the sale of a depreciable asset attributable to a lack of wear and tear at the rate assumed by the depreciation reimbursement formula, and "gains resulting from other factors that do not in any way suggest or imply that the provider has been compensated for any consumption of its

assets that did not in fact occur." *Id.* at 1558. The Court of Appeals concluded:

> "To the extent that inflation or market supply and demand characteristics are responsible for the excess of sales price over book value in a transaction such as occurred in this case, the Secretary's position retroactively deprives providers of reimbursements made for the consumption of their assets without regard to whether those payments in fact overcompensated the provider for reasonable costs actually incurred. Such an interpretation of Regulation 405.415(f) is clearly contrary to the statutory mandate." *Ibid.*[7]

The rejection of *Mercy Community Hospital* by the Court of Appeals for the First Circuit in this case was wrong. The Court of Appeals for the First Circuit concluded that in view of the needs for administrative convenience, the "artificial" nature of the concept of depreciation, and the fact providers know the rules in advance, it could not "say the unfairness is great enough to make the depreciation recapture rule unreasonable." *Hoodkroft Convalescent Center, Inc., supra,* 879 F.2d at 975, App. at 15a.

Yet nowhere did the Court of Appeals address the fundamental problem with the respondents' position: that New Hampshire's interpretation of its regulations does

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[7] The Court of Appeals also observed that a contrary ruling would create an imbalance between the treatment of capital assets leased by the provider, and those purchased by the provider. It noted that the regulations permit reimbursement of "all lease or rental payments made to secure the services of long-lived assets as long as the assets would be depreciable if the provider owned them outright." 781 F.2d at 1557 n.6. Because "[r]ental payments on depreciable assets whose market value is increasing as they are being consumed can be expected to increase in each year in which the market value of the assets increased," the Court of Appeals said, the Secretary's position created an incentive "for no apparent reason" favoring the rental of capital assets over their purchase. *Id.* at 1558 n.7.

not compensate the provider for the actual costs of wear and tear to its capital assets. Given the nature of capital assets—buildings and medical equipment, for example—such costs will often constitute a large part of a provider's expenses for participating in the Medicaid program. Yet the Court of Appeals found it "reasonable" for the Secretary to leave such large costs un-reimbursed after a sale upon gain. This blinks economic reality. It contravenes the intent of Congress.[8]

The Court of Appeals resurrected the familiar hobgoblin of "administrative inconvenience" as a main reason for affirming the District Court. Such inconvenience as might exist can be alleviated simply by placing on the provider the burden of showing what portion of the gain on sale resulted from inflation or market factors. The respondents have shown nothing to indicate that in the populous States that the Court of Appeals for the Eleventh Circuit comprises, the Medicare machinery has ground to a halt because of the ruling in *Mercy Community Hospital.*

Nor should depreciation principles applicable under the Internal Revenue Code or State public utility regulations control this issue. Whatever may be the practice under other statutory schemes, the question here is not the fairness of New Hampshire's policy in the abstract, but whether that policy is a reasonable effectuation of the command of Congress to reimburse providers for their actual costs. Regardless what public utility authorities

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[8] The 1984 Medicare Act amendment which the Court of Appeals and the District Court both cited, P.L. 98-369, § 2314, 98 Stat. 1079, *codified at* 42 U.S.C. § 1395x(v)(1)(O)(i), *et seq.*, was concerned with re-valuation of the basis of a depreciated capital asset by the new owner after a sale of that asset. Nothing in the scanty legislative history of the amendment indicates that Congress in any way considered the issue presented by this Petition. See H.R. Conf. Rep. No. 98-861. 98th Cong., 2d Sess. 757, 1338-1339 (1984), *reprinted in 1984 U.S. Code Cong. & Ad. News* 1445, 2026-2027.

may say to justify their practices in that discrete area of law, New Hampshire's policy does not conform to the Congressional mandate.

The decision of the Court of Appeals for the First Circuit in the case presented by this Petition conflicts directly with that of the Court of Appeals for the Eleventh Circuit in *Mercy Community Hospital*, notwithstanding that this case involves Medicaid, while *Mercy Community Hospital* involved Medicare. This is so because New Hampshire has predicated its Medicaid reimbursement policy squarely on the federal Medicare regulations at issue in *Mercy Community Hospital*, 42 C.F.R. § 405.415, thus making the proper interpretation of that Medicare regulation the controlling question.

Indeed, at least eight other States in addition to New Hampshire follow the Medicare policy expressly in providing for recapture.[9] Eleven other States provide for partial recapture to a greater or lesser extent, and have clearly been influenced by the Medicare regulations in doing so.[10] (At least 23 of the remaining 30 States do not recapture depreciation at a gain on sale.[11])

The courts below have ignored the real economic cost to petitioners of placing capital assets in service in the Medicaid program. The Medicaid Act mandates that these costs be reimbursed, as the Court of Appeals for the Eleventh Circuit recognized (by analogy) in *Mercy Community Hospital*. Plenary review by this Court is warranted to correct the lower courts' departure from the requirements of the Medicaid Act.

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[9] The eight additional States are Iowa, Nebraska, Nevada, New Mexico, Pennsylvania, Tennessee, Vermont, and Virginia. *E.g.*, Iowa Medicaid State Plan Attachments 4.19C & 4.19D.

[10] The eleven states are Alabama, Florida, Idaho, Kansas, Maine, Michigan, Minnesota, Mississippi, North Carolina, Ohio, and Rhode Island. *E.g.*, Ala. Medicaid Agency Administrative Code, Chapter 22.

[11] *E.g.*, Ariz. Dept. of Health Services Regulations 4-1-7.18.

CONCLUSION

The Petition for Writ of Certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX

APPENDIX

UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

No. 89-1083

HOODKROFT CONVALESCENT CENTER, INC., *et al.*,
Plaintiffs, Appellants,

v.

STATE OF NEW HAMPSHIRE,
DIVISION OF HUMAN SERVICES, *et al.*,
Defendants, Appellees.

Appeal from the United States District Court
for the District of New Hampshire
[Hon. Shane Devine, *U.S. District Judge*]

Before

Bownes and Breyer, *Circuit Judges*,
and Gray,* *Senior District Judge*

E. Donald Dufresne with whom *Amy L. Ignatius* and *Devine, Millimet, Stahl & Branch Professional Association* were on brief for appellants.

Gretchen Leah Witt, Assistant United States Attorney, with whom *Peter E. Papps*, Acting United States Attorney, was on brief for appellee Dr. Otis R. Bowen, M.D., Secretary of the Department of Health and Human Services.

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* Of the Central District of California, sitting by designation.

Susan S. Geiger, Assistant Attorney General, Civil Bureau, with whom *John P. Arnold*, Attorney General, was on brief for appellee State of New Hampshire, Division of Human Services.

July 14, 1989

BREYER, *Circuit Judge*. The State of New Hampshire, acting under the federal government's Medicaid program, reimburses nursing homes for Medicaid-related costs, including depreciation of their buildings and equipment. A nursing home that paid $300,000, for example, for an item with a 30 year estimated useful life, would be reimbursed $10,000 each year for 30 years. But if the nursing home sells the item at a profit, New Hampshire's regulations provide for "recapture" of past depreciation payments. Thus, if the nursing home sold the item in Year 10 for $600,000, it must return to the State the $100,000 in depreciation payments that it would, by then, have received. And, it must do so even if the high resale price reflects nothing more than a dollar cheapened by the ravages of inflation. The appellants in this case claim that these New Hampshire regulations are unlawful, at least when the profits upon resale are due solely to inflation. We, like the district court, *Hoodkroft Convalescent Center* v. *State of New Hampshire*, 701 F. Supp. 17 (D.N.H. 1988), reject the appellants' arguments, and find that the regulations are lawful.

I.

Background

The federal Medicaid program provides money for the states to pay for medical care for needy and disabled people. *See* Title XIX of the Social Security Act, 42 U.S.C. § 1396. A state receiving federal Medicaid funds

must administer them according to a "state plan" that meets federal standards. 42 U.S.C. § 1396a. Under the plan, the state will reimburse nursing homes and other Medicaid facilities for the cost of caring for Medicaid-qualified patients. 42 U.S.C. § 1396a(a)(13). The federal Medicaid statute says that states must

> provide for payment . . . of . . . services provided under the plan through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.

42 U.S.C. § 1396a (a)(13)(A).

The State of New Hampshire, like other states and the federal government, considers that "depreciation" of buildings and equipment is one of the allowable "costs" of providing care. New Hampshire Medical Assistance Manual § 9999.7b(1); *cf.* 42 C.F.R. § 405.415(a) (corresponding federal Medicare regulation) (now renumbered § 413.134(a)). New Hampshire calculates depreciation according to a standard accounting method, dividing an asset's purchase price (say $300,000) by its estimated useful life (say, 30 years), and reimbursing the facility for the resulting annual depreciation ($10,000 each year for 30 years). *See* Medical Assistance Manual § 9999.7b (1)(a); *cf. Richey Manor, Inc.* v. *Schweiker*, 684 F.2d 130, 135 (D.C. Cir. 1982) (same method of calculating depreciation applies under 42 C.F.R. § 405.415). If the facility sells the asset, New Hampshire, like the federal government and other states, "recaptures" the depreciation it has paid, to the extent that the sale price exceeds the depreciated original cost of the asset (*i.e.*, the original purchase price less all depreciation payments made before the sale). *See* Medical Assistance Manual § 9999.7b (1)(d); *cf.* 42 C.F.R. § 405.415(f)(1); Idaho Code 56-104 (1988); Kansas Admin. Reg. 30-10-25(3) (1987); Minn. Stat. § 256B.431(3b) (1988); Ohio Admin. Code 5101:3-3-28 (1988); Va. Code 32-1-329 (1988).

In 1974 the Hoodkroft Convalescent Center bought a building and nursing equipment for about $1 million. Over the years New Hampshire paid the Center about $173,000 for depreciation. In 1985 the Center sold the building and equipment for about $3 million, making a profit of about $2 million over the original purchase price. The state would like its depreciation payments back. But, the Center, and its owner, do not wish to pay, and they have brought this declaratory judgment action (removed from state to federal court) attacking the legality of the recapture rule on constitutional and statutory grounds as vague and unfair. We shall consider the Center's basic arguments in turn.

II.

Vagueness

The Center argues that the state's recapture rules are so vague and confusing that they violate the Fifth Amendment of the federal Constitution. We shall for the moment postpone consideration of the constitutional basis for the Center's claim and simply assume that the Medicaid statute itself, in directing the states to set rates, implicitly requires that the rules and regulations embodying those rates be coherent and comprehensible to the facilities regulated. *Cf. Harris* v. *McRae*, 448 U.S. 297, 311 n.17 (1980) (quoting *Broadrick* v. *Oklahoma*, 413 U.S. 601, 608 (1973)) (test for unconstitutional vagueness is whether an "ordinary person exercising ordinary common sense can sufficiently understand and comply with" a law).

In our view, New Hampshire's depreciation recapture regulations, while written in a technical style, adequately convey the basic rule. In 1986, when New Hampshire's Division of Human Services, the agency that administers the Medicaid program, *see N.H.R.S.A.* 161:2, VIII, tried to recapture the depreciation payments here at issue, its recapture rule read as follows:

> If any property is sold at a gain for which Medicaid reimbursement for depreciation has been received, such gain shall be subject to recapture. The extent to which any such reimbursement is recaptured shall be determined by the Bureau of Provider Audits and Rate Setting.

He-W [Health-Welfare regulation] 504.18(p)(6)(b)(1)(iii). This general regulation thus refers to the Bureau of Provider Audits and Rate Setting for a more detailed determination of the extent of recapture. That Bureau uses the Division of Human Services' Medical Assistance Manual. That Manual says (and has said at least since 1977, when the state began making the depreciation payments here at issue) that:

> If any property is sold at a gain for which Medicaid reimbursement for depreciation has been received, such gain shall be subject to recapture. The extent to which any such reimbursement is recaptured is calculated based on [federal Health Insurance Manual] Section 132, Gains and Losses on disposal of Depreciable Assets (Excluding Casualty Losses).

Medical Assistance Manual § 9999.7b(1)(d). The state Medical Assistance Manual thus cross-references the federal Health Insurance Manual § 132, which says

> The net depreciation adjustment on the disposition of depreciable assets includes: (1) *the amount of the gain or loss,* (2) indirectly, the depreciation adjustment on those assets acquired prior to entrance into the program, and (3) depreciation taken in excess of straight line depreciation . . . . With respect to a gain on disposition, *the net depreciation adjustment will be limited to the amount of depreciation accumulated for that asset under the program.*

Health Insurance Manual § 132(C) (first emphasis in original) (now renamed Provider Reimbursement Manual § 132(C)). This federal manual goes on to provide

several examples showing how to calculate depreciation adjustments. *See* HIM §§ 132.1-132.2. These provisions of the federal Health Insurance Manual implement the Medicare regulation analogous to the state's Medicaid recapture rule, which says:

> If disposal of a depreciable asset results in a gain or or loss, an adjustment is necessary in the provider's allowable cost. The amount of a gain included in the determination of allowable cost shall be limited to the amount of depreciation previously included in Medicare allowable costs. The amount of a loss to be included shall be limited to the undepreciated basis of the asset permitted under the program.

42 C.F.R. § 405.415(f)(1). Although these rules and regulations require the reader to look up various cross-references, taken as a whole they are reasonably clear and specific. They are the kind of rules that the Center's lawyers or accountants ought to understand.

The Center says that confusion arises because the state Medical Assistance Manual uses the word "recapture" of depreciation, while the federal Health Insurance Manual that it cross-references uses the word "adjustment" instead. But the difference simply reflects the fact that the federal Manual governs not only recapture of depreciation payments when the owner sells the property at a gain, but also payment of additional depreciation when the owner sells the property at a loss. *See* 42 C.F.R. § 405.415(f)(1). The Center also finds confusion in the fact that, from 1976 to 1984, the state's He-W regulation used the same language as the state Manual uses now. In 1984 the state amended it to say that the amount of recapture "shall be determined by the Bureau of Provider Audits," instead of saying that it shall be "calculated based on HIM Section 132." This change, however, does not make the rules vague or contradictory. The state He-W regulation now simply designates the entity responsible for calculating the amount of recapture; the

method of calculation to be followed by the Board is still stated in the Manual.

There are two other reasons why the Center should have understood the reimbursement ground rules, including the rules providing for depreciation recapture. First, the Center signed a reimbursement contract with the state. In that contract, it promised to "abide by all rules and regulations promulgated by the Division of Human Services pertaining to the . . . claiming of payments." Both the He-W regulation and the Medical Assistance Manual provision on recapture are "rules and regulations promulgated by the Division of Human Services." Second, a substantial body of case law interprets the federal regulations to which New Hampshire's rules refer, making it clear that they provide for depreciation recapture and how they do so. *See, e.g., Richey Manor*, 684 F.2d at 135 (under 42 C.F.R. § 405.415(f), "if the selling price is higher than the cost basis, a gain is recognized, and Medicare recaptures the amount by which depreciation reimbursements exceeded actual depreciation"); *Sumner* v. *United States*, 678 F.2d 202, 206 (Ct. Cl. 1982); *Professional Medical Care Home, Inc.* v. *Harris*, 644 F.2d 589, 592 (7th Cir. 1980); *Gosman* v. *United States*, 573 F.2d 31, 35 (1978) (Ct. Cl. (1978) [*sic*]; *Adventist Living Centers, Inc.* v. *Bowen*, 686 F. Supp. 680, 683 (N.D. Ill. 1988); *Hillhaven Corp.* v. *Schweiker*, 570 F. Supp. 248, 250 (M.D. La. 1983).

All this is to say that the government gave Hoodkroft more than adequate notice about the rules of the game, through the use of language that, though technical, an "ordinary person exercising ordinary common sense," *Harris*, 448 U.S. at 311 n.17, would understand. Thus, the State violated neither the federal statute, nor the Constitution's prohibition against taking "property" without due process of law. (This is so even if we assume that the Center had an "entitlement" to, and hence a property interest in, the depreciation payments, *see*

Board of Regents v. *Roth*, 408 U.S. 564, 577 (1972), which assumption, since the state set forth its recapture rules clearly from the beginning, we very much doubt.)

III.

Fairness

The Center's more important argument focuses on the federal Medicaid statute's requirement that the state set "rates . . . reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 U.S.C. § 1396a(a)(13)(A). Hoodkroft says that the wear and tear suffered by its build-in and equipment, over eight years, is such a "cost;" that the gain from the sale of that property reflected only inflation, not an absence of wear and tear; and that, by recapturing the depreciation, the state unlawfully set a rate that was not "reasonable and adequate to meet" this cost of wear and tear.

To return to our example, assume that a nursing home bought equipment with a 30 year expected useful life for $300,000. It would depreciate the equipment for 30 years at a rate of $10,000 per year. Suppose that after 10 years, when the depreciated value of the equipment was only $200,000, the facility sold it for $600,000. The equipment, says the facility, is still used up and in bad condition; the high price reflects only inflation. Indeed, the facility says, the same equipment in perfect condition would sell, in Year Ten, for $900,000 (since prices between Year One and Year Ten have trebled due to inflation). So, in its view, the wear and tear deprived it of an additional $300,000 profit. Yet the recapture rule would take back the $100,000 the facility received for depreciation between Year One and Year Ten. The Center says the recapture rule is, therefore, unfair, to the point where it is not "reasonable and adequate" to compensate the Center for its necessary costs of operation, as 42 U.S.C. § 1396a(a)(13)(A) mandates. At the

least, the Center says, the state must interpret its recapture rule so as to exempt, on a case-by-case basis, gains that are proven to reflect only inflation, rather than a lack of actual wear and tear.

The Eleventh Circuit has accepted a version of this argument. It has held that the federal recapture regulation, 42 C.F.R. § 405.415(f)(1), violates the Medicare statute's similar mandate to reimburse health care providers for all reasonable costs. *Mercy Community Hospital* v. *Heckler*, 781 F.2d 1552 (11th Cir. 1986). The court reasoned that, because the recapture rule fails to distinguish between gains that merely reflect "inflation or market supply and demand characteristics," and gains that reflect a lack of depreciation, it "deprives providers of reimbursements made for the consumption of their assets without regard to whether those payments in fact overcompensated the provider for reasonable costs actually incurred." *Id.*, 781 F.2d at 1558. The Seventh Circuit and the Court of Claims, however, have held to the contrary. *See Professional Medical*, 644 F.2d at 592-94; *Stewards Foundation* v. *United States*, 654 F.2d 28, 34 (Ct. Cl. 1981).

We think the latter decisions are correct. In our view, the state and federal recapture rules represent a reasonable, and therefore lawful, interpretation of the Medicaid statute, for the following reasons.

First, 42 U.S.C. § 1396a(a)(13)(A) says that the state plan must use rates that "the *State finds*, and makes assurances *satisfactory to the Secretary*, are reasonable and adequate." The statute, explicitly, and relevant principles of administrative law, implicitly, give to the State and the Secretary broad legal power to determine the scope of the statutory words "reasonable and adequate." *See Chevron U.S.A., Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844 (1984) ("considerable weight should be accorded to an [agency's] construction

of a statutory scheme it is entrusted to administer"); *International Brotherhood of Teamsters* v. *Daniel*, 439 U.S. 551, 566 n.20 (1979); *Mayburg* v. *Secretary of Health & Human Services*, 740 F.2d 100, 106 (1st Cir. 1984). Here, both the Secretary, in promulgating a recapture regulation for Medicare, *see* 42 C.F.R. § 405.415 (f) (1), and the State in its own rulemaking, have taken the view that the recapture rule is consistent with § 1396a (a) (13) (A). Indeed, Congress itself has provided some indication that the recapture rule is consistent with the purposes of the Medicaid statute, for Congress, in 1984, amended the Medicare Act, but told the Secretary to "provide for recapture of depreciation in the same manner as provided under the regulations in effect on June 1, 1984," that is, in the same manner as under 42 C.F.R. § 504.515(f) [*sic*]. 42 U.S.C. § 1395x(v) (1) (O) (ii); *see* 1984 U.S. Code Cong. & Admin. News 2026 (under the new statute, the "Secretary would be required to continue recapture of the depreciation as under current reimbursement policy").

Second, the law can, and often does, use the concept of "depreciation costs" to refer not to a physical fact (*e.g.*, that a piece of equipment is worn), nor to an economic fact (*e.g.*, that wear and tear makes it less valuable than a new piece of equipment), but rather to an accounting fact, namely, a certain percentage of the nominal, historical price paid for the item. Of course, the percentage is not totally arbitrary; it should in general reflect the economic fact that the value of equipment will sink to zero over time. But since it is difficult to devise a depreciation formula that will accurately reflect short-run changes in economic value, a depreciation allowance typically "represents, not the actual changes in value from year to year but a stylized allowance for a downward trend." J. Bonbright, A. Danielson & D. Kamerschen, *Principles of Public Utility Rates*, 276 (1988); *see also Montana Power Co.* v. *F.E.R.C.*, 599 F.2d 295, 300 (9th

Cir. 1979) ("Because the market value of assets seldom changes precisely in accordance with depreciation, depreciated original cost often is not an accurate proxy of current fair market value"); A. Kahn, *The Economics of Regulation* I, 27, 32 (1988). This "stylized allowance" promises no more than that an investor will eventually receive back the historical, nominal dollars that he invested in an asset.

Indeed, the Internal Revenue Code uses a similar "stylized" approach when it measures taxable gain as nominal dollar profit upon resale of property, and disregards the possibility that a nominal gain upon sale may be due only to inflation, *see* 26 U.S.C. §§ 1001(a), 1011(a), 1012, 1016(a)(2) (taxable gain on sale of property is the difference between sale price and "adjusted basis" (*i.e.*, original cost less depreciation)), and when, in certain circumstances, it taxes the "recaptured depreciation" portion of a gain at higher "ordinary income" rates. 26 U.S.C. § 1245(a) (gain from sale of certain depreciable assets is "ordinary income," up to the amount of past depreciation taken as tax deductions). These provisions of the Internal Revenue Code, like New Hampshire's recapture rule, do not distinguish between dollar gains due to less-than-expected wear and tear, and those due only to inflation.

Third, New Hampshire's recapture rule is similar to rules that regulators traditionally apply to public utilities. The regulatory system typically promises the regulated firm only a reasonable dollar profit calculated as a percentage of investment, as measured by historical, nominal dollar costs. Bonbright, *supra*, at 212, 305 (the "original-cost or net-investment principle of ratemaking" is the majority rule, and this principle "goes a considerable distance toward establishing the relevant tests of a fair rate of return"); Kahn, *supra*, at I, 41, 89 (most states use a rate base "representing actual money outlays;" the "traditional and still generally followed ap-

proach of public utility regulation . . . assur[es] a reasonable gross return on the existing investment"). Consistently with that basic premise, utility regulators typically measure depreciation, as does New Hampshire, in terms of a percentage of nominal historical dollars invested in an asset. Bonbright, *supra*, at 276-77 (the depreciation method "now most generally applied by public uitlities, amortizes the costs of assets (minus net salvage) through equal annual charges over estimated service lives"); Kahn, *supra*, at I, 117 (typical current practice in utilities regulation is to calculate the utility's yearly depreciation allowance by prorating the historic cost of its assets over their "total estimated economic life"); *see, e.g.*, Mass. Gen. Laws Ann. Ch. 164 § 57 (gas and electric companies can include in rate base "an amount for depreciation equal to three per cent of the cost of the plant"). Regulators typically do not adjust the cost basis of an asset to reflect inflation. *See* Kahn, *supra*, at I, 109-116 (discussing problem that original cost ratemaking does not take inflation, and other economic factors, into account); Bonbright, *supra*, at 342-48 (same).

And, if the utility later sells the asset at a profit, the ratepayer, not the utility, has been held entitled to receive the benefit of the gain, at least to the extent of recapturing past depreciation allowances. *See A T & T Information Systems, Inc.* v. *F.C.C.*, 854 F.2d 1442, 1444 (D.C. Cir. 1988) (because "ratepayers generally assume the risk of loss on depreciable assets used in a utility's operations," they "have the superior claim to capital gains achieved on depreciable assets"); *Democratic Central Committee* v. *Washington Metropolitan Area Transit Commission*, 842 F.2d 402, 412 (D.C. Cir. 1988) ("farepayers should receive the benefit of the actual gain" on sale of depreciable property); *Bebchick* v. *Washington Metropolitan Area Transit Commission*, 645 F.2d 1086, 1090 (D.C. Cir. 1981) ("in recovering depreciation

Transit's investors are entitled to recover no more or less than their [historic] cost"); *Montana Power Co.*, 599 F.2d at 300; *Democratic Central Committee* v. *Washington Metropolitan Area Transit Commission*, 485 F.2d 786, 795 (D.C. Cir. 1973) (when a utility sells depreciable property at a gain, the gain is used " 'to reduce the depreciation expenses which ratepayers have paid but which the company, because of the gain, does not actually incur' "); *Washington Public Interest Organization* v. *Public Service Commission*, 393 A.2d 71, 74 (D.C. App. 1978) ("ratepayers, who have been charged for depreciation of plant facilities, should be repaid with the gains, if any, upon eventual sale of those facilities"); *Maine Water Co.* v. *Public Utilities Commission*, 482 A.2d 443, 448 (Me. 1984) ("customers of a utility that sells at a gain *depreciable* property . . . have a right to have that gain applied to reduce their future rates"); *South County Gas Co.* v. *Burke*, 551 A.2d 22, 24-25 (R.I. 1988) (upholding commission's ruling that a portion of sale profits reflecting "the amount that the ratepayers paid toward the depreciation expense of the property" should go to reduce future rates); *Rate Case of Commonwealth Electric Co.*, No. DPU 88-135/151, 90-94 (Mass. Dept. of Public Utilities, Jan. 31, 1989) (when utility sells depreciable assets at a price that exceeds their net book value (historic cost minus depreciation) the gain goes to reduce future rates).

This regulatory practice seems relevant because one basic purpose of the Medicaid program, like utility regulation, is to keep rates at reasonable levels. *See* 42 U.S.C. § 1396a(13)(A) [*sic*] (limiting rates to those adequate for "efficiently and economically operated facilities"). And, the Medicaid program, like utility regulation, gives participating facilities a guarantee that they will, at least, recover nominal, historical dollars invested. These similarities seem great enough to warrant a similar conclusion about the reasonableness of comparable cost measuring rules.

Fourth, the main reason that utility regulators, and presumably Medicaid administrators, use historical, nominal dollars to calculate depreciation and other costs is administrative efficiency. To try to measure the current value of a facility each year; to try to assess the actual yearly economic losses caused by equipment wear and tear; to try to determine the extent to which any gain on resale reflects (a) less-than-expected wear and tear, (b) inflation, or (c) special market factors such as shortages, all would pose formidable administrative difficulties. Consider, for example, the conflicting evidence and expert testimony that parties might tender on such matters. Justices Brandeis and Holmes described these difficulties convincingly in their attack on the "fair value" ratemaking rule of *Smyth* v. *Ames*, 169 U.S. 466 (1898), in *State of Missouri ex rel Southewestern Bell* v. *Public Service Commission*, 262 U.S. 276, 289-312 (1923) (Brandeis & Holmes, JJ., dissenting). It is not surprising that the law has come to reflect Justices Brandeis' and Holmes' position. *See Federal Power Commission* v. *Hope Natural Gas Co.*, 320 U.S. 591 (1944) (rejecting "fair value" approach and, in effect, permitting regulatory commissions to use original cost basis in ratemaking).

Fifth, it is difficult to say that the "historical cost" system, despite its failure to take inflaction into account, is seriously unfair, as long as a facility and its investors understand the ground rules in advance. *Cf. Kahn, supra*, at I, 115-16 (any scheme of compensation is fair to utility investors if they are informed of its terms in advance, including whether or not it will protect them from inflation). It is not unfair to treat a facility rather like a bondholder, who lacks protection against inflation but enpoys security of nominal dollar return. New Hampshire, through Medicaid, simply guarantees its nursing homes that they will recover the actual dollar costs of their investment in buildings and equipment. (Indeed, it also lets them keep any dollar profit on resale re-

maining after they pay back the taxpayer for depreciation payments.) To require this recapture is to say that the nursing home can recover nominal dollars invested but once, not twice, irrespective of inflation. That is, reimbursement for depreciation purports only to replace, over time, the original, historic cost of the asset, so, if the asset does not in fact fall to zero value over time, but instead is resold at a profit, then its original cost is recovered by the resale and, by definition, no "depreciation" has occurred. New Hampshire has simply fashioned a reimbursement system that is indifferent as to whether the dollars that reimburse come from inflation, special economic conditions, less-than-expected wear and tear, or any other source. Although there are obvious fairness problems that arise whenever a tax, regulatory, or cost reimbursement system is indifferent to inflation in this way, if the parties know in advance that the rules treat them somewhat like investors in bonds, we cannot say the unfairness is great enough to make the depreciation recapture rule unreasonable.

In sum, given the breadth of the Medicaid's statute's delegation to the states and the Secretary to determine what counts as a "reasonable" system for reimbursing costs, the analogies with treatment of depreciation elsewhere in the law, the reasons of administerability that argue for the use of nominal, historic cost-based rate system, and the lack of any unfair surprise, we agree with the Seventh Circuit and the Court of Claims that New Hampshire's Medicaid recapture rule is within the boundaries of the Medicaid statute, and is therefore lawful.

For these reasons, the judgment of the district court is

Affirmed.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW HAMPSHIRE

Civil No. 87-312-D

HOODKROFT CONVALESCENT CENTER; NORMAN TURCOTTE

v.

THE STATE OF NEW HAMPSHIRE, DIVISION OF HUMAN SERVICES; DR. OTIS R. BOWEN, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

ORDER

[Filed Dec. 2, 1988]

In this federal question action,[1] plaintiffs Hoodkroft Convalescent Center ("Hoodkroft") and Norman Turcotte seek a declartion that they are not obligated to pay the State of New Hampshire $173,089 as "recapture of depreciation", originally paid to plaintiffs as a part of their reimbursement for care of Medicaid patients. The matter is before the Court on the parties' cross-motions for summary judgment.

Hoodkroft is a nursing home located in Derry, New Hampshire, which at all relevant times was owned by Turcotte. Hoodkroft began participating in the State Medicaid program in 1974, under which it was reimbursed for care of Medicaid patients at a per diem rate determined by the State. This per diem rate included reimbursement for depreciation of Hoodkroft's capital

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[1] Jurisdiction is asserted by way of 28 U.S.C. § 1331.

assets. From July 1, 1977, to July 31, 1985, Hoodkroft claimed $321,902 in depreciation expense as an allowable cost. During this same period, the New Hampshire Medicaid program reimbursed the plaintiffs for $173,089 of this expense.

On July 31, 1985, Turcotte sold the equipment, land, and buildings used in the operation of Hoodkroft to McKerley Health Facilities for a total purchase price of $3 million. Plaintiffs realized a gain on their depreciable assets of $2,325,081. On March 11, 1986, the New Hampshire Division of Health and Human Services ("Division"), Bureau of Provider Audits, notified Mr. Turcotte that he owed the State of New Hampshire the $173,089 as "recapture of depreciation" by authority of the Medicaid Reimbursement Manual, page 12, item III(d) ("Sale of Depreciable Assets at a Gain"). Thus, the amount sought to be recaptured represents the entire amount of depreciation expense Hoodkroft received from July 1, 1977, until July 1985, when Hoodkroft was sold.

Plaintiffs appealed the Bureau of Provider Audits' decision to the Division of Human Services on September 26, 1986. On February 2, 1987, the Administrator of the New Hampshire Office of Fair Hearings issued an order staying action on the administrative appeal pending judicial review of the applicable rules. Plaintiffs subsequently filed this action to resolve the legal questions.

Standard of Review

The same standard of review afforded federal agency action applies to the action of a state agency administering federal Medicaid funding. *Friedman* v. *Perales*, 668 F. Supp 216, 221 (S.D.N.Y. 1987), *aff'd* 841 F.2d 47 (2d Cir. 1988). A reviewing court is required to grant "considerable deference" to an agency's official interpretation of statutory terms and should uphold an agency's interpretation if it is "reasonable and defensible". *De-*

partment of the Navy v. *Federal Labor Relations Auth.*, 854 F.2d 1, 4 (1st Cir. 1988). A provider bears a difficult and heavy burden of proving that the agency's interpretation conflicts with the statutory scheme. *See Mercy Community Hosp.* v. *Heckler*, 781 F.2d 1552, 1555 (11th Cir. 1986).

Relevant Law

Congress enacted the federal Medicaid program to enable the states to furnish medical assistance to needy people. Title XIX of the Social Secuirty Act, 42 U.S.C.A. § 1396 (1983 & Supp. 1988). Each state must submit a plan for approval to the Secretary of Health and Human Services. The state plan must "provide for payment of . . . services provided under the plan through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, *are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. . . .*" 42 U.S.C. § 1396a(a)(13)(A) (Supp. 1986) (emphasis added). Upon approval of the plan, the state and federal governments share the costs of this program, which is administered by the state. *See* 42 U.S.C. §§ 1396a and 1396b.

In New Hampshire, the New Hampshire Division of Human Services is charged with the admininstration of the Medicaid program. *See* New Hampshire Revised Statutes Annotated (RSA) 161:2 VI. The State has developed a plan which has been approved by the Secretary of Health and Human Services. As part of its Medicaid plan, the State has incorporated the "recapture of depreciation" rule [2] promulgated by the Secretary un-

[2] 42 C.F.R. § 413.134(f) (1987) provides in part that "if disposal of a depreciable asset results in a gain or loss, an adjustment is necessary in the provider's allowable cost. The amount of gain included in the determination of allowable cost is limited to the amount of depreciation previously included in Medicare allowable costs."

der the Federal Medicare program, Title XVIII of the Social Security Act, 42 U.S.C. § 1395, *et seq.*[3] *See* New Hampshire Medical Assistance Manual ("MAM") § 9999.7b (1) (d). In essence, the state rule provides that property sold at a gain for which Medicaid reimbursement has been received is subject to recapture of depreciation.[4]

Discussion

The Medicaid Act requires states to pay providers for all reasonable costs incurred. *See* 42 U.S.C. § 1396a(a) (13) (A). Although the New Hampshire Medicaid program recognizes depreciation as an allowable cost, *see* MAM § 9999.7b(1), it authorizes recapture of that depreciation when property is sold at a gain. The Government reasons that under such circumstances depreciation is not a cost actually incurred. Plaintiffs assert that, despite the increase in Hoodkroft's market value, the assets depreciated, as that term is used under the "reasonable cost method" of accounting; i.e., there was wear and tear on the assets which caused a decrease in their value. Plaintiffs reason that the gain in the property's value could be attributable to market forces and does not neces-

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[3] The Medicare Act, enacted concurrently with the Medicaid Act, is a health insurance program for retired and disabled individuals which is administered by the federal government.

[4] MAM § 9999.7b(1) (d) provides:

> (D) [*sic*] Sales of Depreciable Assets at a Gain.
>
> If any property is sold at a gain for which Medicaid reimbursement or depreciation has been received, such gain shall be subject to recapture. The extent to which any such reimbursement is recaptured is calculated based on HIM-15 § 132, Gains and Losses on Disposal of Depreciable Assets (excluded casualty losses) [*sic*].

"HIM" stands for Health Insurance Manual and refers to the federal manual used by the Secretary to administer the Medicare program. The HIM has been redesignated the Provider Reimbursement Manual ("PRM"), and the relevant section regarding recapture of depreciation is now PRM-1 § 132C.

sarily mean that the property did not depreciate. Thus, plaintiffs conclude that the State of New Hampshire's recapture policy is contrary to the Act because it deprives them of reimbursement for the cost of the depreciation their capital assets incurred while they were used in the Medicaid program.

The Court finds that the Secretary and the State of New Hampshire have reasonably concluded that a facility which has been sold at a gain has not actually incurred the cost of appreciation. *See Professional Medical Care Home, Inc.* v. *Harris*, 644 F.2d 589, 593-94 (7th Cir. 1980); *see also Stewards Found.* v. *United States*, 654 F.2d 28, 34 (Ct. Cl. 1981); *but see Mercy Community Hosp., supra*, 781 F.2d at 1557. The purpose of the recapture rule is to "avoid allowances for depreciation which turn out not to have been a 'cost actually incurred.'" *Professional Medical, supra*, 644 F.2d at 593. Although plaintiffs are correct in noting that their capital assets suffered wear and tear, the State reasonably concludes that this is not a cost incurred when the property is sold at a gain. "Depreciation is not an easy cost to compute; it is unavoidably artificial." *Adams Nursing Home of Williamstown, Inc.* v. *Mathews*, 548 F.2d 1077, 1081 n.12 (1st Cir. 1977). Courts should not be "inclined to substitute [their] notions of proper accounting for those of the Secretary." *Id.*[5]

Moreover, effective July 18, 1984, Congress amended the Medicare Act to specifically approve of the Secretary's recapture policy. *See* Pub. L. No. 98-369, § 2314, 98 Stat. 1079 (1984). This amended section states that the Secretary "shall provide for recapture of depreciation in the

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[5] Plaintiffs' argument that the use of the word "adjustment" in 42 C.F.R. § 413.134(f), *see supra* note 2, precludes a complete "recapture" of depreciation is without merit. Because the regulation applies when assets are sold at a gain or a loss, the term "adjustment" is a neutral characterization of the alteration which may take place.

same manner as provided under the regulations in effect on June 1, 1984." 42 U.S.C. § 1395x(v)(1)(O)(ii); *see also* 1984 U.S. Cong. & Adm. News 2026 (under the amendment, the "Secretary would be required to continue recapture of depreciation as under current reimbursement policy.") The Secretary's reimbursement policy is set forth in 20 C.F.R. § 405.415(f), as well as in a provider reimbursement manual (PRM) which is distributed to the states. PRM-1 § 132C, upon which the Division relied in fashioning its recapture policy, is reasonably construed as providing for recapture of depreciation in the event that an asset is sold at a gain. Thus, the Court finds that Congress specifically approved of the Secretary's policies regarding recapture of depreciation—the same policies adopted by the State of New Hampshire in its Medicaid program and challenged by the plaintiffs herein.

The Court also rejects plaintiffs' contention that the recapture rule impermissibly shifts depreciation expense to private patients, contrary to 42 U.S.C. § 1395x(v)(1)(A).[6] This statutory provision applies to the *Medicare* program, and it has not been adopted by the State of New Hampshire in its Medicaid plan. However, even if this provision does apply to Medicaid, Hoodkroft has not incurred any actual depreciation expense, and theretofore a shifting of this "cost" could not have occurred. Moreover, if Hoodkroft were able to keep reimbursement in excess of the amount to which it is entitled, costs would be shifted from private patients to Medicaid patients, contrary to this provision.

Plaintiffs also argue that, even if the rule is valid, they are due a return on equity capital. Plaintiffs reason that

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[6] That section provides in relevant part that in determining reasonable costs "the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs . . . ."

because the State has adopted the Medicare regulations in determining reasonable costs under the Medicare program, it must also adopt the Medicare statutory provision which provides a return on equity capital to certain proprietary providers. *See* 42 U.S.C. § 1395x(v)(1)(B).

Congress intended that state authorities have great flexibility in determining costs and setting rates under the Medicaid program. *Alabama Nursing Home Ass'n* v. *Harris*, 617 F.2d 388, 392 (5th Cir. 1980). The states are free to experiment with methods and standards for payment. *Id.* Therefore, although the State of New Hampshire has the discretion to adopt Medicare regulations in determining reasonable costs under the Medicaid program, it is not required to do so, and certainly is not required to adopt the entire Medicare regulatory scheme. Moreover, the Medicaid Act requires that providers be reimbursed for reasonable *costs*, and a return on equity capital is "a profit, not a cost." *Sun Towers, Inc.* v. *Heckler*, 725 F.2d 315, 335 (5th Cir.), *cert. denied*, 469 U.S. 823 (1984).

Plaintiffs also argue that the Division's rule on recapture of depreciation is unconstitutional. Plaintiffs first assert that the New Hampshire Legislature's grant of authority to the Division is an unconstitutional delegation of power because the State has not given the Division directives regarding the manner in which it should develop and administer the Medicaid program.

The basic purpose behind the nondelegation doctrine is to prevent administrative agencies from exercising unguided and uncontrolled discretionary power. *See* K. Davis, *Administrative Law Treatise* § 3:15 (1978). This sentiment has been echoed by the New Hampshire Supreme Court, which has stated that "a law is invalid when its commands are in such broad terms as to leave the enforcement agency with unguided and unrestricted discretion in the assigned field of its acivity. . . ." *Ferretti* v. *Jackson*, 88 N.H. 296, 302, 188 A. 474 (1936).

The Court finds that the Division did not exercise unrestricted discretion in fashioning its regulations regarding Medicaid reimbursement, and thus there has been no constitutionally impermissible delegation of authority. Even plaintiffs acknowledge that the Division's discretion is not unguided. In fact, plaintiffs complain in another section of their argument that the Division's adherence to federal Medicare directives has impermissibly tainted its impartiality.

The federal Medicaid program was established as a cooperative federal/state partnership. *Gilman* v. *Helms*, 606 F. Supp. 644, 654 (D.N.H. 1985). States are not required to participate in the Medicaid program, but if they do, they must comply with all requirements imposed by the Social Security Act and its implementing regulations. *Massachusetts Ass'n of Older Americans* v. *Sharp*, 700 F.2d 749, 750 (1st Cir. 1983); *see also Gilman, supra*, 606 F. Supp. at 654. Congress intended for state Medicaid agencies to promulgate regulations implementing the Medicaid program, *see Carbon Hill Health Care, Inc.* v. *Beasley*, 528 F. Supp. 421, 423 (M.D. Ala. 1981), and gave them broad discretion to do so. Thus, the Division appropriately exercised its discretion when it relied on Deparment of Health and Human Services Medicare regulations and policy manuals in enacting its rules regarding the recapture of depreciation. *Cf. Potter* v. *James*, 499 F. Supp. 607, 611-12 (M.D. Ala. 1980) (in construing Social Security regulations, the court is not limited to bare words of the regulations, but may consider HHS's medical assistance manual).

Moreover, several safeguards exist to prevent the Division from taking arbitrary action. The State plan, which contains the provisions regarding Medicaid reimbursement, has been approved by the United States Department of Health and Human Services. Additionally, the State of New Hampshire has explicitly recognized the need for state rules to comply with federal law and has

created a ten-member oversight committee on health and welfare to "recommend changes in state statutes and rules [which] may be necessary in order to comply with any changes in federal law and federal regulations." RSA 126-A:9 (Supp. 1987). Because the New Hampshire Legislature has not improperly delegated its authority, and because the Division of Health and Human Services has properly relied on federal directives in fashioning its rules, the Court finds no constitutional violation.[7]

Finally, plaintiffs assert that the State's rule regarding recapture of depreciation is impermissibly vague and overbroad and that recapture would constitute a taking of plaintiffs' property without due process of law in violation of the New Hampshire and United States Constitutions. In essence, plaintiffs assert that they were not on notice that their depreciation reimbursement would be subject to recapture in the event the property were sold at a gain.

The Due Process Clause of the Fourteenth Amendment requires that statutes or regulations be sufficiently specific to provide fair notice of what they prescribe. *Brasslet* v. *Cota*, 761 F.2d 827, 838 (1st Cir. 1985). In this case, Hoodkroft was on notice that depreciation would be subject to recapture. The relevant rule clearly states, "if any property is sold at a gain for which Medicaid reimbursement for depreciation has been received, such gain shall be subject to recapture." He-W 504.18(p)(6)(b)(1)(iii). And although the rule does not state the

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[7] Hoodkroft also argues that the Division's rule regarding recapture conflicts with the fundamental purpose of the Medicaid system, and thus the Division has exceeded the discretion granted to it by the Legislature. The Court has already determined that the Division's rule on recapture is consonant with the Medicaid Act, and accordingly rejects this argument.

precise manner in which recapture will be calculated,[8] the State's Medicaid plan and the State's policy and procedure manual for Medicaid providers do set forth these procedures. *See* MAM § 9999.7b(1)(d). Both documents refer to the provider reimbursement manual, PRM-1 § 132, which describes how the net depreciation adjustment upon disposal of depreciable assets is to be computed and gives examples. These provisions were in effect at all times relevant to Hoodkroft's participation in the Medicaid program.[9] Because the plaintiffs were on notice that their assets were subject to recapture, the Court finds the relevant regulations are not unconstitutionally vague.[10]

Additionally, the plaintiffs have not been deprived of a constitutionally-protected property right. Such a right exists when one has a current valid expectation based on the Government's implied promise to continue an entitlement in an important personal monetizable interest. *Cervoni* v. *Secretary of HEW*, 581 F.2d 1010, 1018 (1st Cir. 1978). Here, plaintiffs were on notice that their depreciation expense would be subject to recapture, and thus they did not have a valid expectation that they were entitled to keep the depreciation expense reimbursement. Accordingly, they did not have a cognizable property interest.

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[8] The rule states that recapture "shall be determined by the Bureau of Provider Audits and Rate Setting." *Id.*

[9] He-W 504.18(p)(6)(b)(1)(iii) did not become effective until August 16, 1984. However, its precursor, SR 78-115, was filed with the Office of Legislative Services in August 1978, with an effective date of October 1, 1976. The rule contained in SR 78-115 is identical to MAM § 9999.7(b)(1)(d).

[10] Moreover, contrary to plaintiffs' assertion that the State did not enforce the recapture rule prior to the time Hoodkroft was sold, an affidavit submitted by Perry Wescott from the New Hampshire Bureau of Provider Audits avers that the recapture program has been in operation since July 1, 1977, and that between that date and the date on which the Hoodkroft facility was sold ten other facilities were sold and their assets were subject to recapture.

Cf. Cheshire Hosp. v. *New Hampshire-Vermont Hospitalization Services*, 689 F.2d 1112, 1122 (1st Cir. 1982) (reliance on one's own interpretation of imprecise regulation does not create an entitlement based on that interpretation, or a violation of due process when the administrator or court adopts another reading).

Summary judgment is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Rule 56(c), Fed. R. Civ. P. The burden is on the moving party to establish the lack of a genuine material factual issue. *Finn* v. *Consolidated Rail Corp.*, 782 F.2d 13, 15 (1st Cir. 1986). The Court must view the record in the light most favorable to the party opposing the motion, according it all beneficial inferences discernable from the evidence. *Oliver* v. *Digital Equip Corp.*, 846 F.2d 103, 105 (1st Cir. 1988).

In this case, no genuine factual dispute exists. Because the State of New Hampshire has reasonably construed the relevant statutory and regulatory provisions in recapturing Hoodkroft's depreciation, the Court finds and rules that the defendants are entitled to judgment as a matter of law. Accordingly, defendants' motions for summary judgment (documents no. 17 and 20) are herewith granted, and plaintiffs' motion for summary judgment (document no. 15) is herewith denied.

SO ORDERED.

/s/ Shane Devine
Chief Judge
United States District Court

December 2, 1988

cc: Martha V. Gordon, Esq.
Susan S. Geiger, Esq.
Gretchen Leah Witt, Esq.

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

No. 89-1083

HOODKROFT CONVALESCENT CENTER, *et al.*,
Plaintiffs, Appellants,

v.

THE STATE OF NEW HAMPSHIRE,
DIVISION OF HUMAN SERVICES, *et al.*,
Defendants, Appellees.

JUDGMENT

Entered: July 14, 1989

This cause came on to be heard on appeal from the United States District Court for the District of New Hampshire, and was argued by counsel.

Upon consideration whereof, It is now here ordered, adjudged and decreed as follows: The judgment of the district court is affirmed.

By the Court:

FRANCIS P. SCIGLIANO
Clerk

By: /s/ Daniel F. Loughry
Chief Deputy Clerk

[cc: Mr. Dufresne and Ms's Witt and Geiger]

42 U.S.C. § 1396a

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

* * * *

(13) provide—

(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1395x(v)(1)(G) of this title)) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports

by each hospital, skilled nursing facility, and intermediate care facility and periodic audits by the State of such reports;

* * * *

N.H. Rule He-W 504.18(p)

504.18 (p) *Reimbursement*

The Division of Welfare shall reimburse on the basis of actual allowable costs which are reasonable, necessary and related to patient care.

* * * *

(6) *Guidelines for Allowable/Non-Allowable Costs*

The following guidelines define allowable/non-allowable costs. Decisions governing the allowability of costs not specifically detailed within the manual shall be based on HIM 15 Guidelines in effect at the time of such determination.

* * * *

b. Depreciation of Equipment and Property of Proprietary, Voluntary and Public Providers

1. Depreciation

An appropriate allowance for depreciation of equipment and property shall be an "allowable cost".

i. General

The depreciation shall be:

(i) Identifiable and recorded in the provider's accounting records.

(ii) Based on the historical cost of the asset or fair market value at the time of donation in the case of donated assets.

(iii) Prorated over the estimated useful life of the asset using the straight-line method and the guideline lives suggested by the CCH Medicare and Medicaid Guide,

"Estimated useful life of land improvements, buildings and fixed equipment."

ii. Recording of depreciation

Appropriate recording of the depreciation shall encompass the identification of the depreciable assets in use, the assets' historical costs, the method of depreciation, estimated useful life, and the assets' accumulated depreciation.

iii. Sales of depreciable assets at a gain

If any property is sold at a gain for which Medicaid reimbursement for depreciation has been received, such gain shall be subject to recapture. The extent to which any such reimbursement is recaptured shall be determined by the Bureau of Provider Audits and Rate Setting.

iv. Depreciation shall be allowed on assets financed with Hill-Burton or other federal or public funds.

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N.H. MEDICAL ASSISTANCE MANUAL
SECTION 9999.7

Subject: NURSING HOME REMIBURSEMENT

Date: 5/85

SR 85-29

Guidelines for Allowable/Non Allowable Costs 9999.7

* * * *

b. *Depreciation of equipment and property of proprietary, voluntary and public providers*

(1) *Depreciation*

An appropriate allowance for depreciation of equipment and property is an "allowable cost".

(a) *General*

The depreciation must be:

i. *Identifiable and recorded* in the provider's accounting records.

ii. Based on the historical cost of the asset or fair market value at the time of donation in the case of donated assets.

iii. Prorated over the estimated useful life of the asset using the straight-line method and the guideline lives suggested by the CCH Medicare and Medicaid Guide, "Estimated useful life of land improvements, buildings and fixed equipment".

(b) *Definitions*

i. *Historical cost* is the cost incurred by the present owner in acquiring the asset. Depreciation is allowed on assets financed with Hill-Burton or other federal or public funds.

However, in establishing an appropriate allowance for depreciation and for interest on capital indebtedness with respect to an asset of a nursing facility which has undergone a change of ownership, the valuation of the asset shall be the lesser of the allowable acquisition cost of such asset to the owner of record as of July 18, 1984 (or in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner. Costs (including legal fees, accounting and administrative costs, travel costs and costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset for which payment has previously been made shall not be recognized as reasonable in the provision of health care services.

ii. *Fair Market Value*

Fair Market Value is the price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition.

iii. *The straight-line method*

Under the straight-line method of depreciation, the cost or other basis (e.g. fair market value in the case of donated assets) of the assets, less its estimated salvage value, if any, is determined first. Then this amount is distributed in equal amounts over the period of the estimated useful life of the asset.

(c) *Recording of depreciation*

Appropriate recording of the depreciation encompasses the identification of the depreciable assets in use, the assets' historical costs, the method of depreciation, estimated useful life, and the assets' accumulated depreciation.

(d) *Sales of depreciable assets at a gain*

If any property is sold at a gain for which Medicaid reimbursement for depreciation has been received, such gain shall be subject to recapture. The extent to which any such reimbursement is recaptured is calculated based on HIM-15 Section 132, Gains and Losses on Disposal of Depreciable Assets (Excluding Casualty Losses).

(2) *Leasing arrangements for property*

(a) *General*

Some lease agreements are essentially the the same as installment purchases of equipment. If the lease is a virtual purchase, the rental charge is includable in allowable costs only to the extent that it does not exceed the amount which the provider would have included in allowable costs had he bought the asset.

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MEDICARE PROVIDER REIMBURSEMENT MANUAL-1, SECTION 132

DEPRECIATION

132. GAINS AND LOSSES ON DISPOSAL OF DEPRECIABLE ASSETS (EXCLUDING INVOLUNTARY CONVERSIONS)

Where the intermediary has not made a final determination of allowable costs before December .., 1973, then the following instructions will be followed. Where the intermediary has made a final determination of allowable costs by employing other methodology that it found appropriate under prior instructions, in the determination of adjustments arising from disposal of depreciable assets prior to this issuance, the cost report will not be reopened in order to comply with the requirements of this section. However, where a provider has claimed accelerated depriciation and is subject to the provisions of § 136, as well as this section, the provisions for recovery of accelerated depreciation are effective even where final settlement has been made.

A. Gains and losses on the disposition of depreciable assets are includable as applicable, either in computing allowable cost or in computing the adjustment to Medicare reimbursable cost, depending upon the manner of disposition of the asset and the amount of the net depreciation adjustment. Any type of asset may be disposed of by sale. Scrapping, as defined in section 104.19, however, is limited to tangible personal properties which (1) can be physically removed from the provider's premises, (2) are no longer useful for their intended purpose, and (3) are only salable for their scrap or junk value. Structures such as buildings which cannot easily be moved are usually demolished or abandoned when useless. However, certain building components such as

doors, fixtures and elevators that can be detached from the building shell can be either demolished or scrapped. The manner of disposition is the criterion, not the asset type.

1. *Bona Fide Sale or Scrapping.*—Gains and losses realized from a bona fide sale or scrapping of a depreciable asset are includable as an adjustment of depreciation in the period of disposal under the criteria in section 123.3.A, or if those criteria are not met, includable as an adjustment to Medicare reimbursable costs under section 132.3B. or C. based on an allocation of the gains and losses to periods during which depreciation was allowed under the program for the disposed assets. Gains and losses may be recognized on a bona fide sale which occurs while the provider is either participating in the program or within 1 year immediately following the date on which the provider terminates participation in the Medicare program. However, gains and losses are recognized only on scrapping that occurs while the provider is participating in the program. If several assets are sold for a lump sum sales price, the gain or loss on the sale of each depreciable asset must be determined by allocating the lump sum sales price among all the assets sold on the basis of the fair market value of each asset at the time of sale. If the buyer and seller cannot agree on an allocation of the sales price, or if they do agree but there is insufficient documentation of the current fair market value of each asset, the intermediary for the selling provider shall require an appraisal by an independent appraisal expert to establish the fair market value of each asset and shall make an allocation of the sales price in accordance with the appraisal.

2. *Exchange, Trade-in or Donation.*—Gains and losses realized from the trade-in, donation, or exchange of depreciable assets are not included in the determination of allowable cost. (See section 104.11.)

3. *Demolition or Abandonment.—*

a. *Treatment of Gains and Losses on a Depreciable Asset as Defined in Section 104.21 or 104.22*—Losses on demolition include the demolition cost incurred by the provider for razing and removal of the asset, less any salvage value recovered by the provider. In situations where a provider is both selling or scrapping while abandoning or demolishing other assets, the provisions for treatment of a gain or loss from a sale or scrapping will be applied separately from those for treatment of a gain or loss from abandonment or demolition.

If the aggregate loss (net depreciation adjustment) from all demolitions and abandonments during the cost reporting period:

(1) does not exceed $5,000, the loss is allowed in the period of disposal (see section 132.3A(2)),

(2) exceeds $5,000 and each asset is at least 80 percent depreciated as computed under the straight-line method at the date of disposition, the loss is allowable as stated in section 132.3B, or

(3) exceeds $5,000, and each demolished or abandoned asset is not 80 percent depreciated as computed under the straight-line method at the date of disposition, it must be capitalized as a deferred charge and amortized as follows:

(a) *Abandonment or Demolition Approved by the State Health Planning and Development Agency (SHPDA), or The Regional Office*—The net loss realized must be capitalized as a deferred charge and amortized over the remaining life of the demolished or abandoned asset, or at the rate of $5,000 per year, whichever is greater. If no SHPDA exists or if such agency is unable or unwilling to perform this function, the provider must submit a request for approval to the intermediary. After reviewing the request, the intermediary shall submit the

request along with its recommendation to the regional office for its approval.

(b) *Abandonment or Demolition Not Approved by SHPDA or the Regional Office*—The net loss realized is not allowable unless the demolished or abandoned asset is replaced. If replaced, the net loss realized must be capitalized as a deferred charge and then amortized over the estimated useful life of the replacement asset or at the rate of $5,000 per year, whichever is greater.

b. *Demolition of an Asset for the Purpose of Preparing Land for Future Sale*—The net demolition cost incurred by the provider (razing and removal costs less salvage recovered) on a depreciable asset shall be considered a capital expenditure and added to the historical basis of the land. If a provider purchases land on which there is a building, no depreciation is reimbursable unless the building is used in providing patient care. If the building is demolished, the entire purchase price and demolition cost is considered the historical cost of the land. However, if the building is used for patient care, but demolished within 5 years of purchase, the entire purchase price less allowed depreciation, plus demolition cost shall be considered the historical cost of the land.

4. *Sale of a Replacement or Restored Asset*—If a provider sells a replacement or restored asset while participating in the Medicare program or within 1 year immediately following its date of termination from the Medicare program, the unrecovered loss entered on the books of the provider as a deferred charge in accordance with 132.A.3.(a)(3), will not be included in determining the gain or loss realized from the sale of the replacement or restored asset. However, if the sale of such asset is made to a related organization as defined in section 1002.1 and the purchasing organization continues as a provider in the Medicare program, the remaining deferred charge representing the unrecovered depreciable

basis of the demolished or abandoned asset shall continue to be amortized over the remaining expected useful life of the replacement or restored asset. If the sale is made to an unrelated provider, further amortization of the deferred charge is not allowed.

5. *Involuntary Conversions.*—The treatment of gains and losses realized from the involuntary conversion, i.e., casualty losses, is specified in section 133.

6. *Unrecovered Losses-Equity Capital Treatment.*—The unrecovered loss entered on the book of the provider as a deferred charge in situations involving demolitions or casualty losses, is not includable in the computation of equity capital (see section 1218.13).

B. Where a provider terminates participation in the program atfer July 1970, disposes of *all* of its depreciable assets, *AND* is subject to recovery of accelerated depreciation in accordance with the provisions of § 136, then the methodology contained in §§ 132ff. will be followed to determine the adjustment to Medicare reimbursable cost. Where a provider has a decrease in HI utilization that meets the requirements for recovery of accelerated depreciation as described in § 136, then such recovery must be made first in accordance with the provisions of § 136 before computing the gain or loss. Where recovery has been made under § 136, the adjusted book value is taken into account in the calculation of the net depreciation adjustment applicable to subsequent disposals of such assets.

C. The net depreciation adjustment on the disposition of depreciable assets includes: (1) the amount of the gain or loss, (2) indirectly, the depreciation adjustment on those assets acquired prior to entrance into the program, and (3) depreciation taken in excess of straight-line depreciation for a provider that disposes of all of its depreciable assets and is subject to recovery of accelerated depreciation in accordance with the requirements

described in § 136. With respect to a gain on disposition, *the net depreciation adjustment will be limited to the amount of depreciation accumulated for that asset under the program.*

The methods to determine the net depreciation adjustment are contained in §§ 132.1 and 132.2. The methods to allocate the net depreciation adjustment are contained in § 132.3. Finally, the methods to determine the adjustment to Medicare reimbursable cost are contained in § 132.4.

D. Where an asset acquired in a nonbona fide sale is subsequently disposed of, the gain or loss on disposition is based on the historical cost of the asset in the hands of the seller last owning the asset as a result of a bona fide acquisition and the calculation of gain or loss shall include the accumulated depreciation taken under the program by both the seller and the purchaser in the nonbona fide sale.

E. Where a provider has elected to be reimbursed for depreciation using the optional allowance and did not subsequently change to actual depreciation prior to the disposal of the asset, no gain or loss is recognized upon disposal of the asset. If the provider initially elected the optional allowance but subsequently changed to actual depreciation, gain or loss will be recognized on disposal of the asset and the net depreciation adjustment is applicable to the periods in which actual depreciation is claimed.

132.1 *Computation of Net Depreciation Adjustment upon Disposal of Depreciable Assets Acquired Before the Provider's Entrance Into the Program.*—When an asset is disposed of, a recomputation of the net book value based on actual useful life must be made in determining the net depreciation adjustment. The actual useful life will cover the period from date of acquisition to date of

disposal. The examples below show the methods used to determine the net depreciation adjustment applicable to years under the program.

Under the procedure used in Example 1 and 2, the actual salvage value (sales price) is deducted from historical cost in determining the basis for depreciation. The basis is allocated to determine the adjusted depreciation applicable to the period under the program. The difference between the adjusted depreciation applicable to that period under the program and the actual depreciation taken during that period is the net depreciation adjustment.

Example 3 shows the computation of the net depreciation adjustment where a provider disposes of its depreciable assets and is subject to recovery of accelerated depreciation in accordance with the requirements described in § 136. The net depreciation adjustment is determined by combining the gain or loss applicable to the period under the program with the depreciation taken in excess of straight-line depreciation.

EXAMPLES

Facts Applicable to Examples 1, 2, and 3 Below:

Provider entered the program 7/1/68		
Historical cost—7/1/58		$330,000
Estimated salvage value		15,000
Amount to be depreciated		$315,000
Estimated useful life		30 years
Actual useful life		
Asset acquired before entrance into the program—7/1/58		10 years
Useful life under the program—asset sold 6/30/73		5 years
Total actual useful life		15 years
Depreciation taken before entrance into the program—straight-line method		
(Years—not under the program) 10 / (Years—estimated useful life) 30	x $315,000 =	$105,000
Sales price—6/30/73		$183,000

EXAMPLE 1—COMPUTATION OF NET DEPRECIATION ADJUSTMENT WHERE ACCELERATED DEPRECIATION WAS CLAIMED BY PROVIDER

Historical cost—7/1/58		$330,000
Actual salvage value—price 6/30/73		183,000
Basis for depreciation		$147,000
Depreciation adjusted for period not under the program		
(Years—not under the program) 10 / (Years—actual useful life) 15	x $147,000	98,000
Depreciation adjusted for period under the program		$ 49,000
Depreciation taken under the program-sum-of-the-years' digits method $315,000—$105,000=$210,000 ÷ 210 units (20 years)=$1,000 x 90 units (5 years)=		$ 90,000
Depreciation adjusted for the period under the program		49,000
Net depreciation adjustment—Excess depreciation taken		$ 41,000

EXAMPLE 2—COMPUTATION OF NET DEPRECIATION ADJUSTMENT WHERE STRAIGHT-LINE DEPRECIATION WAS CLAIMED BY PROVIDER

Historical cost—7/1/58		$330,000
Actual salvage value--sale price 6/30/73		183,000
Basis for depreciation		$147,000
Depreciation adjusted for period not under the program		
(Years—not under the program) 10		
(Years—actual useful life) 15	x $147,000=	98,000
Depreciation adjusted for period under the program		$ 49,000
Depreciation taken under the program—straight-line method		
(Years—under the program) 5		
Years—estimated useful life) 30	x $315,000=	$ 52,500
Depreciation adjusted for period under the program		49,000
Net depreciation adjustment—Excess depreciation taken		$ 3,500

EXAMPLE 3—COMPUTATION OF NET DEPRECIATION ADJUSTMENT APPLICABLE WHERE A PROVIDER CLAIMED ACCELERATED DEPRECIATION, TERMINATES PARTICIPATION IN THE PROGRAM AFTER JULY 1970, AND DISPOSES OF ITS DEPRECIABLE ASSETS

Computation of Depreciation in Excess of Straight-Line Depreciation

Depreciation taken before entrance into the program	$105,000
Depreciation taken under the program-sum-of-the-years' digits method—$315,000−$105,000=$210,000÷210 units (20 years)=$1,000 x 90 units (5 years)=	90,000
Total depreciation taken on disposed assets	$195,000
Depreciation adjusted to straight-line method (Years—actual useful life) 15 / (Years—estimated useful life) 30 x $315,000=	157,000
Depreciation in excess of straight-line depreciation	$ 37,500

Computation of Gain (or Loss)

Sales price—6/30/73		$183,000
Historical cost—7/1/58	$330,000	
Depreciation adjusted to a straight-line method	157,500	
Unrecovered cost		172,500
Gain on sale		$ 10,500

Computation of Net Depreciation Adjustment

Gain applicable to years under the program (Years—under the program) 5 / (Years—actual useful life) 15 x $1,500=	$ 3,500
Depreciation in excess of straight-line depreciation	$ 37,500
Net depreciation adjustment—Excess depreciation taken	$ 41,000

132.2 *Computation of Net Depreciation Adjustment Upon Disposal of Depreciable Assets Acquired Under the Program.*—The methodology for computation of the net depreciation adjustment on depreciable assets acquired under the program is the same as used in § 132.1, in that, for examples 1 and 2 below, the actual salvage value is the sales price which is deducted from historical cost to determine the basis for depreciation. The difference between the basis for depreciation and the actual depreciation taken is the net depreciation adjustment.

Example 3 shows the computation of the net depreciation adjustment applicable where a provider disposes of its depreciable assets and is subject to recovery of accelerated depreciation in accordance with the requirements described in § 136. The net depreciation adjustment is determined by combining the gain or loss with the depreciation taken in excess of straight-line depreciation.

EXAMPLES

Facts Applicable to Examples 1, 2, and 3 Below:

Historical cost—7/1/67	$490,000
Estimated salvage value	25,000
Amount to be depreciated	$465,000
Estimated useful life	30 years
Actual useful life	6½ years
Sales price—12/31/73	$300,000

EXAMPLE 1—COMPUTATION OF NET DEPRECIATION ADJUSTMENT WHERE ACCELERATED DEPRECIATION WAS CLAIMED BY PROVIDER

Historical cost—7/1/67	$490,000
Actual salvage value—sales price 12/31/73	300,000
Basis for depreciation	$190,000
Depreciation taken-sum-of-the-years' digits method $465,000:465 units (30 years) = $1,000 per unit x 177 units (6½ years) =	$177,000
Basis for depreciation	190,000
Net depreciation adjustment—Additional depreciation allowed the provider	($ 13,000)

EXAMPLE 2—COMPUTATION OF NET DEPRECIATION ADJUSTMENT WHERE STRAIGHT-LINE DEPRECIATION WAS CLAIMED BY PROVIDER

Historical cost—7/1/67	$490,000
Actual salvage value—sales price—12/31/73	300,000
Basis for depreciation	$190,000
Depreciation taken—straight-line method	
$465,000: 30 (years) = $15,500 per year x 6½ years=	$100,750
Basis for depreciation	190,000
Net depreciation adjustment—additional depreciation allowed the provider	($ 89,250)

EXAMPLE 3—COMPUTATION OF NET DEPRECIATION ADJUSTMENT APPLICABLE WHERE A PROVIDER CLAIMED ACCELERATED DEPRECIATION, TERMINATES PARTICIPATION IN THE PROGRAM AFTER JULY 1970, AND DISPOSES OF ITS DEPRECIABLE ASSETS

Computation of Depreciation in Excess of Straight-Line Depreciation

Depreciation taken-sum-of-the-years' digits method $465,000÷465 units (30 years) = $1,000 per unit x 177 units (6½ years) =	$177,000
Depreciation adjusted to straight-line method (Years—actual useful life) 6½ / (Years—estimated useful life) 30 x $465,000=	100,750
Depreciation in excess of straight-line depreciation	$ 76,250

Computation of Gain (or Loss)

Sales price—12/31/73		$300,000
Historical cost—7/1/67	$490,000	
Depreciation adjusted to a straight-line method	100,750	
Unrecovered cost		389,250
Gain (or loss) on sale		($ 89,250)

Computation of Net Depreciation Adjustment

Loss on sale	($ 89,250)
Depreciation in excess of straight-line depreciation	76,250
Net depreciation adjustment	($ 13,000)

132.3 *Allocation of Net Depreciation Adjustments.*—A provider will allocate its total net depreciation adjustments as determined in §§ 132.1 and 132.2 in accordance with the particular circumstances of either A, B, or C below. Where a provider does not have the depreciation or Medicare utilization information that is contained in the cost reports and is needed for the allocation or determination of adjustment to reimbursable costs for years prior to the 5-year limitation on retention of records, then the provider will request such records from the intermediary. Where the intermediary does not have such records, the intermediary will request the necessary information from SSA.

A. *Allocation Permitted in the Year of Disposal.*—A provider shall reflect the net depreciation adjustment as an adjustment of depreciation in the year of disposal where either:

1. the HI utilization, based on cumulative total of Medicare covered days for all reporting periods in which depreciation on the asset disposed of was claimed under the Medicare program, is less than 5 percent of the cumulative total of inpatient days in the facility (certified area only) for the same reporting periods; or

2. the net depreciation adjustments applicable to all disposals of depreciable assets within the cost reporting period total $5,000 or less.

B. *Allocation Where Provider is not Subject to Recovery of Accelerated Depreciation.*—Where a provider is not subject to recovery of accelerated depreciation in accordance with the provisions of § 136; when the conditions of paragraph A of this section are not met; and when in the case of demolished or abandoned assets, the assets are at least 80 percent depreciated, the provider will allocate the net depreciation adjustment to each reporting period based on the ratio of the total depreciation allowed on the disposed assets in each reporting

period to the total depreciation applicable to such assets for all reporting periods under the program. The facts applicable to Example 1 of § 132.1 are used in the example below to demonstrate how the net depreciation adjustment is allocated to each reporting period under the program by multiplying the $41,000 by the ratio of depreciation determined for each period.

Allocation of Net Depreciation Adjustment to Each Reporting Period Under the Program.—

Cost Report Period Ending	Disposed Asset Depreciation Per Cost Report	Percent Reporting Period Depreciation to Total Depreciation	Allocation of Net Depreciation Adjustment
6/30/69	$20,000	22	$ 9,020
6/30/70	19,000	21	8,610
6/30/71	18,000	20	8,200
6/30/72	17,000	19	7,790
6/30/73	16,000	18	7,380
Total	$90,000	100	$41,000

C. *Allocation Where Provider Terminates and is Subject to Recovery of Accelerated Depreciation.*—Where a provider terminates participation in the program after July 1970; disposes of its depreciable assets and does not meet the conditions of paragraph A; and where in the case of demolished or abandoned assets, the assets are at least 80 percent depreciated, the net depreciation adjustment will be allocated to each reporting period under the program as follows:

1. The portion of the recomputed depreciation (straight-line method) that is applicable to reporting periods under the program is distributed proportionately to such periods.

2. The recomputed depreciation amount for each reporting period is compared to the actual taken in each period. The difference is the excess depreciation to be recovered.

3. The gain or loss is allocated proportionately to each reporting period under the program and is combined with the excess depreciation for that period to determine the net depreciation adjustment.

The following facts (taken from Example 3, § 132.1) will demonstrate how the net depreciation adjustment is allocated to each reporting period under the program.

Step 1—Recomputed depreciation $157,500 less depreciation taken before entrance into the program $105,000 equals $52,500 which is divided by the five equal periods to arrive at $10,500 for each period.

Step 2—In the schedule below, recomputed depreciation (column 3) is compared with actual depreciation taken (column 2) to arrive at excess depreciation (column 4).

Step 3—Excess depreciation (column 4) is combined with gain or loss (column 5) to arrive at net depreciation adjustment (column 5).

Allocation of Net Depreciation Adjustment to Each Reporting Period Under the Program.—

(1) Fiscal Year Ending	(2) Actual Depreciation Taken	(3) Recomputed Depreciation	(4) Excess Depreciation (2)-(3)	(5) Gain on Sale	(6) Net Depreciation Adjustment (4)-(5)
6/30/69	$20,000	$10,500	$ 9,500	$ 700	$10,200
6/30/70	19,000	10,500	8,500	700	9,200
6/30/71	18,000	10,500	7,500	700	8,200
6/30/72	17,000	10,500	6,500	700	7,200
6/30/73	16,000	10,500	5,500	700	6,200
Total	$90,000	$52,500	$37,500	$3,500	$41,000

132.4 *Methods Available for Determination of Adjustment to Reimbursable Cost.—*

A. Paragraph A of § 132.3 describes the conditions under which a provider reflects the total net depreciation as an adjustment of depreciation in the year of disposal. Where these conditions are not met, a provider must first allocate the net depreciation adjustment to periods under the program in accordance with the provisions of paragraph B or C of § 132.3. After the net depreciation for each reporting period under the program is determined:

1. The provider will compute the adjustment to reimbursable cost based upon the ratio of the program's share of reimbursable cost to total cost (see paragraph B);

2. On request of the provider, the intermediary may grant permission for the provider to compute the adjustment to reimbursable cost under the method described in paragraph C, if the provider can show that the direct costs of ancillary services furnished under arrangements in any cost reporting period, subject to recovery, are 10 percent or more of the direct costs of all ancillary services furnished;

3. Any provider may at its option compute the adjustment to reimbursable cost by recalculating, for each reporting period, all the necessary cost reporting schedules applicable to each reporting period covered by the depreciation adjustments. Schedules recomputed in accordance with this option must be submitted with the cost report for the cost reporting period in which the gain(s) or loss(es) giving rise to the depreciation adjustments took place.

The same method of computation must be used for all periods affected by the net depreciation adjustments that occur in the current reporting period.

B. *Adjustment to Reimbursable Cost Based Upon the Ratio of the Program's Share of Reimbursable Cost to*

Total Cost.—The adjustment to reimbursable cost is computed by applying the ratio of Medicare reimbursable cost to total allowable cost for each period to the allowable portion of the net depreciation adjustment for that period. The Medicare reimbursable cost and total allowable cost includes inpatient services, nursing salary differential, outpatient and other Part B services, services provided by interns and residents not under an approved training program and ancillary services—Part B. Also, these amounts are gross allowable costs before deductibles and coinsurance billed to HI beneficiaries, return on equity capital, and the charge differential between semiprivate accommodations and less than semiprivate accommodations.

For each period under the program, that portion of the net depreciation adjustment which is applicable to nonallowable cost centers is excluded from the computation. The nonallowable portion is determined by multiplying the net depreciation adjustment for the period by the ratio of depreciation of nonallowable departments to the total depreciation claimed by the provider. See example in C below. To determine the effect on the Part B Trust Fund, the total adjustment to HI reimbursable cost for each period is multiplied by the ratio of Part B reimbursable cost to total reimbursable cost for each of the same periods. The difference between the adjustment to Part B Trust Fund will be the adjustment to Part A Trust Fund. The two examples below include no nonallowable cost centers.

Facts Applicable to Both Examples Below

Cost Report Period Ending	Total Allowable Cost	HI Allowable Cost	Percent HI Cost to Total Allowable Cost
6/30/69	$640,000	$320,000	50
6/30/70	$630,000	$252,000	40
6/30/71	$600,000	$120,000	20
6/30/72	$580,000	$104,000	18
6/30/73	$570,000	$ 85,500	15

Net Depreciation Adjustment Computed in § 132.3B

Cost Report Period Ending	Percent HI Allowable Cost to Total Allowable Cost	Net Depreciation Adjustment	Adjustment to HI Reimbursable Cost
6/30/69	50	$ 9,020	$ 4,510
6/30/79	40	$ 8,610	$ 3,444
6/30/71	20	$ 8,200	$ 1,640
6/30/72	18	$ 7,790	$ 1,402
6/30/73	15	$ 7,380	$ 1,107
		$41,000	$12,103*

Net Depreciation Adjustments Computed in § 132.3C

Cost Report Period Ending	Percent HI Allowable Cost to Total Allowable Cost	Net Depreciation Adjustment	Adjustment to HI Reimbursable Cost
6/30/69	50	$10,200	$ 5,100
6/30/71	40	$ 9,200	$ 3,680
6/30/71	20	$ 8,200	$ 1,640
6/30/72	18	$ 7,200	$ 1,296
6/30/73	15	$ 6,200	$ 930
		$41,000	$12,646*

* This net adjustment is applied as a decrease to the extent of the HI reimbursable cost in the current cost reporting period and any excess not applied is treated as an overpayment to be recovered from the provider.

NOTE: Proprietary providers subject to recapture of accelerated depreciation can determine the effect that the net depreciation adjustment has on the computation of equity capital in accordance with the instructions contained under § 136.10ff. There is no similar prior year adjustment to equity capital for gains and losses on disposal of assets.

C. *Apportionment of Net Depreciation Adjustment Based on Routine and Ancillary Utilization.*—If the provider can demonstrate to the satisfaction of the intermediary that the method of recovery in B above would be inequitable, and can show that the direct costs of ancillary services furnished under arrangement are 10 percent or more of the direct costs of all ancillary services in any cost reporting period subject to the net depreciation adjustment, the intermediary may grant permission for the provider to compute the recovery under the following method.

Step 1—The net depreciation adjustment for each period is first allocated to outpatient services, ancillary services (by ancillary departments where the Departmental Method was used), and nonallowable cost centers, on the basis of the ratio of depreciation (direct expenses to the department) claimed for each of these cost centers to the total depreciation claimed by the provider. The residual net depreciation adjustment not allocated to these centers is then allocated to each routine service cost center on the basis of the ratio of depreciation claimed for each routine cost center to total depreciation claimed for all routine cost centers.

Step 2—The adjustment to HI reimbursable cost for the net depreciation adjustment allocated to each cost center is determined based on the ratio of HI utilization to total utilization in the cost center, and utilizing the same basis for apportionment used in the provider's cost report—i.e., days and/or charges.

Schedule A demonstrates the process used to determine the adjustment to HI reimbursable cost based on a net depreciation adjustment in the amount of $25,920 for the period 12/31/67.

SCHEDULE A
Period ending 12/31/67

	(1) Depreciation per Cost Report	(2) % of Cost Center Depreciation to Total Depreciation	(3) Allocation of Net Depr. Adjustment (Col. 2 x line 1)	(4) Percent HI Program Charges to Total Charges (Per Cost Report Settlement Sheet)	(5) HI Adjustment (4 x 3)
1. Net depreciation adjustment			$35,920		
2. Total depreciation per cost report	$74,139				
3. Departmental Method-Ancillaries Cost of Drugs Sold Physical Therapy					
4. Combination Method Total Ancillaries	$ 1,335	1.8%	$ 467	42.3%	$ 198
5. Nonallowable cost centers Beauty Shop	297	0.4%	104	-0-	
6. Net depreciation adjustment—Subtotal			$ 571		

ROUTINE SUBJECTS		% of Routine Cost Center Depreciation to Total Routine Depreciation	Allocation of Routine Services (Column 2 x Line 10 below)	Percent HI Utilization of Routine Services (Per Cost Report)	
7. Noncertified routine cost center	$23,283	39.7%	$10,064	-0-	
8. Certified routine cost center	35,365	60.3%	15,285	24.7%	3,775
9. Total routine depreciation—certified and noncertified	$58,648	100.0%			
10. Net depreciation adjustment applicable to routine (Line 1-Line 6)			$25,349		
11. HI adjustment					$3,973
12. Allowance in lieu of other costs (See 132.3C)					79
13. Net adjustment to HI reimbursable cost					$4,052

42 C.F.R. 405.415

(a) *Principle.* An appropriate allowance for depreciation on buildings and equipment used in the provision of patient care is an allowable cost. The depreciation must be,

(1) Identifiable and recorded in the provider's accounting records;

2) Based on the historical cost of the asset or fair market value at the time of donation in the case of donated assets; and

(3) Prorated over the estimated useful life of the asset using;

(i) The straight-line method; or

(ii) Accelerated depreciation, under a declining balance method (not to exceed double the straight-line rate) or the sum-of-the-years digits method in the following situations:

(*a*) Depreciable assets for which accelerated depreciation was used for health insurance purposes before August 1, 1970, including those assets for which a timely request to change from straight-line depreciation to accelerated depreciation was received by an intermediary before August 1, 1970;

(*b*) Depreciable assets acquired before August 1, 1970, where no election to use straight-line or accelerated depreciation was in effect on such date and the provider was participating in the program on such date;

(*c*) Depreciable assets of a provider where construction of such depreciable asset began before February 5, 1970, and the provider was participating in the program on February 5, 1970; or

(*d*) Depreciable assets of a provider where a valid written contract was entered into by a provider participating in the program before February 5, 1970, for

construction, acquisition, or for the permanent financing thereof and such contract was binding on a provider on February 5, 1970, and at all times thereafter; or

(iii) A declining balance method, not to exceed 150 percent of the straight-line rate, for a depreciable asset acquired after the date specified in paragraph (h); however, this declining balance method may be used only where the cash flow from depreciation on the total assets of the institution during the reporting period, including straight-line depreciation on the assets in question, is insufficient (assuming funding of available capital not required currently for amortization and assuming reasonable interest income on such funds) to supply the funds required to meet the reasonable principal amortization schedules on the capital debts related to the provider's total depreciable assets. For each depreciable asset for which a provider requests authorization to use a declining balance method for health insurance reimbursement purposes, but not to exceed 150 percent of the straight-line rate, the provider must demonstrate to the intermediary's satisfaction that the required cash flow need exists. For each depreciable asset where a provider justifies the use of accelerated depreciation, the intermediary must give written approval for the use of a depreciation method other than straight-line before basing any interim payment on this accelerated depreciation or making its reasonable cost determination which includes an allowance for such depreciation.

(b) *Definition.* (1) *Historical costs.* Historical cost is the cost incurred by the present owner in acquiring the asset. For depreciable assets acquired after July 31, 1970, the historical cost shall not exceed the lower of current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase or fair market value at the time of the purchase.

(2) *Fair market value.* Fair market value is the price that the asset would bring by bona fide bargaining be-

tween well-informed buyers and sellers at the date of acquisition. Usually the fair market price will be the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.

(3) *The straight-line method.* Under the straight-line method of depreciation, the cost or other basis (e.g. fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is determined first. Then this amount is distributed in equal amounts over the period of the estimated useful life of the asset.

(4) *Declining balance method.* Under the declining balance method, the annual depreciation allowance is computed by multiplying the undepreciated cost of the asset each year by a uniform rate up to double the straight-line rate or 150 percent, as the case may be (see paragraph (a)(3) for limitations on use of accelerated methods of depreciation).

(5) *Sum-of-the-years' digits method.* Under the sum-of-the-years' digits method, the annual depreciation allowance is computed by multiplying the depreciable cost basis (cost less salvage value) by a constantly decreasing fraction. The numerator of the fraction is represented by the remaining years of useful life of the asset at the beginning of each year, and the denominator is always represented by the sum of the years' digits of useful life at the time of acquisition.

(6) *Current reproduction cost.* Current reproduction cost is the cost at current prices, in a particular locality or market area, of reproducing an item of property or a group of assets. Where depreciable assets are concerned, this means the reasonable cost to have built, reproduce in kind, or, in the case of equipment or similar assets, to purchase in the competitive market.

(7) *Useful life.* The estimated useful life of a depreciable asset is its normal operating or service life to the

provider, subject to the provisions in paragraph (b)(7)(i) of this section. Factors to be considered in determining useful life include normal wear and tear; obsolescence due to normal economic and technological changes; climatic and other local conditions; and the provider's policy for repairs and replacement.

(i) *Initial selection of useful life.* In selecting a proper useful life for computing depreciation under the Medicare program, providers must use the useful life guidelines published by HCFA. If HCFA has not published applicable useful life guidelines, providers must use:

(A) The edition of the American Hospital Association useful life guidelines, as specified in HCFA Medicare program manuals; or

(B) A different useful life specifically requested by the provider and approved by the intermediary. A different useful life may be approved by the intermediary if the provider's request is properly supported by acceptable factors that affect the determination of useful life. However, such factors as an expected early sale, retirement, demolition or abandonment of an asset, or termination of the provider from the Medicare program may not be used.

(ii) *Application of guidelines.* The provisions concerning the selection of useful life guidelines described in paragraph (b)(7)(i) of this section apply to assets acquired on or after January 1, 1981. For assets acquired before January 1, 1981, providers must use the useful life guideliness published by the American Hospital Association in its 1973 edition of *Chart of Accounts for Hospitals*, or those published by the Internal Revenue Service, or those approved for use by intermediaries as provided in paragraph (b)(7)(i)(B) of this section.

(iii) *Changing useful life.* A change in the estimated useful life may be made when clear and convincing evi-

dence justifies a redetermination of the useful life used by the provider. Such a change must be approved by the intermediary in writing, and the factors cited in paragraphs (b) (7) and (b) (7) (i) of this section are applicable in making such redeterminations of useful life. If the request is approved, the change is effective with the reporting period immediately following the period in which the provider's request is submited for approval.

(c) *Recording of depreciation.* Appropriate recording of depreciation includes the identification of the depreciable assets in use, the assets' historical costs, the assets' dates of acquisition, the method of depreciation, estimated useful lives, and the assets' accumulated depreciation.

(d) *Depreciation method.* (1) *General.* Proration of the cost of an asset over its useful life is allowed on the straight-line method, or, where permitted under § 405.415 (a) (3), the declining balance or the sum-of-the-years' digits methods. One method may be used on a single asset or group of assets and another method on others. In applying the declining balance or sum-of-the-years' digits method to an asset that is not new, the undepreciated cost of the asset is treated as the cost of a new asset computing depreciation.

(2) *Change in method.* Prior to August 1, 1970, a provider may change from the straight-line method to an accelerated method, or vice versa, upon advance approval from the intermediary on a prospective basis with the request being made before the end of the first month of the prospective reporting period. Only one such change with respect to a particular asset may be made by a provider. Effective August 1, 1970, a provider may only change from an accelerated method or optional method (see § 405.416) to the straight-line method. Such a change may be made without intermediary approval and the basis for depreciation is the undepreciated cost reduced by the salvage value. Thereafter, once straight-line depreciation is selected for a particular asset, an accelerated method may not be established for that asset.

(3) *Recovery of accelerated depreciation.* (i) *General.* When a provider who has used an accelerated method of depreciation with respect to any of its assets terminates participation in the program, or where the health insurance proportion of its allowable costs decreases so that cumulatively substantially more depreciation was paid than would have been paid using the straight-line method of depreciation, the excess of reimbursable cost, determined by using accelerated depreciation methods and paid under the program over the reimbursable cost which would have been determined and paid under the program by using the straight-line method of depreciation will be recovered as an offset to current reimbursement due or, if the provider has terminated participation in the program, as an overpayment. In this determination of excess payment, recognition will be given to the effects the adjustment to straight-line depreciation would have on the return on equity capital and on the allowance in lieu of specific recognition of other costs in the respective years.

(ii) *Transaction between related organizations.* (*a*) *General.* When the termination of the provider agreement is due to a change in provider ownership, as defined in §§ 405.625 and 405.626, resulting from a transaction between related organizations, as defined in § 405.427, and the criteria in paragraph (b) of this section are met, the excess of reimbursable cost, as determined in paragraph (d) (3) (i) of this section shall not be recovered if there is a continuation of participation by the facility in the health insurance program.

(*b*) *Criteria.* The following criteria must be met if the recovery of excess reimbursable cost is not to be made:

(*1*) The termination of the provider agreement is due to a change in ownership of the provider resulting from a transaction between related organizations,

(*2*) The successor provider continues to participate in the health insurance program,

(*3*) Control and the extent of the financial interests of the owners of the provider before and after the termination remain the same; that is, the successor owners acquire the same percentage of control or financial investment as the transferors had, and

(*4*) All assets and liabilities of the terminated provider are transferred to the related successor participating provider.

(c) *Effect of transaction.* In transactions meeting the criteria specified in paragraph (d)(3)(ii)(*b*) of this section, the provision concerning recovery of excess reimburseable cost (§ 405.415(d)(3)(i)) is not applied, and the transaction is treated as follows:

(*1*) The successor provider must record the historical cost and accumulated depreciation and the method of depreciation recognized under the health insurance program, and these are considered as incurred by the successor provider for health insurance purposes;

(*2*) The health insurance program's utilization of the terminated provider is considered has having been incurred by the successor provider for health insurance program purposes; and

(*3*) The equity capital of the terminated provider as of the closing of its final cost reporting period must be wholly contained in the equity capital of the successor provider as of the beginning of its first cost reporting period.

(e) *Funding of depreciation.* Although funding of depreciation is not required, it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciable assets, and coordinate their planning of capital expenditures with areawide planning activities of community and State agencies. As an incentive for funding, investment income on funded depreciation will not be treated as a reduction of allowable interest expense.

(f) *Gains and losses on disposal of assets.* (1) *General.* Depreciable assets may be disposed of through sale, scrapping, trade-in, exchange, demolition, abandonment, condemnation, fire, theft, or other casualty. If disposal of a depreciable asset results in a gain or loss, an adjustment is necessary in the provider's allowable cost. The amount of a gain included in the determination of allowable cost shall be limited to the amount of depreciation previously included in Medicare allowable costs. The amount of a loss to be included shall be limited to the undepreciated basis of the asset permitted under the program. The treatment of the gain or loss depends upon the manner of disposition of the asset, as specified in paragraphs (f) (2) through (f) (6) of this section.

(2) *Bona fide sale or scrapping.* (i) Except as specified in paragraph (f) (3) of this section, gains and losses realized from the bona fide sale or scrapping of depreciable assets are included in the determination of allowable cost only if the sale or scrapping occurs while the provider is participating in Medicare. The extent to which such gains and losses are included is calculated by prorating the basis for depreciation of the asset in accordance with the proportion of the assets' useful life for which the provider participated in Medicare. For purposes of this paragraph (f) (2) (i), scrapping refers to the physical removal from the provider's premises of tangible personal properties which are no longer useful for their intended purpose and are only salable for their scrap or junk value.

(ii) If the total amount of gains or losses realized from bona fide sales or scrapping does not exceed $5,000 within the cost reporting period or if the provider's cumulative utilization under the Medicare program is less than 5 percent, the net amount of gains or losses realized from sale or scrapping shall be allowed as a depreciation adjustment in the period of disposal. For purposes of this paragraph (f) (2) (ii), the provider's cumulative Medi-

care utilization percentage is determined by comparing the cumulative total of the Medicare inpatient days for all reporting periods in which depreciation on the asset disposed of was claimed under the Medicare program to the cumulative total of inpatient days of the participating provider for the same reporting periods.

(iii) If the conditions specified in paragraph (f) (2) (ii) of this section are not met, the adjustment to reimbursable cost in the reporting period of asset disposition shall be calculated as follows:

The total amount of gains or losses shall be allocated to all reporting periods under the Medicare program, based on the ratio of the depreciation allowed on the assets in each reporting period to the total depreciation allowed under the Medicare program. The results of this allocation are multiplied by the ratio of Medicare reimbursable cost to total allowable cost for each reporting period. The results of this multiplication are then added.

(iv) If a provider sells more than one asset for a lump sum sales price, the gain or loss on the sale of each depreciable asset must be determined by allocating the lump sum sales price among all the assets sold, in accordance with the fair market value of each asset as it was used by the provider at the time of sale. If the buyer and seller cannot agree on an allocation of the sales price, or if they do agree but there is insufficient documentation of the current fair market value of each asset, the intermediary for the selling provider shall require an appraisal by an independent appraisal expert to establish the fair market value of each asset and shall make an allocation of the sales price in accordance with the appraisal.

(3) *Sale within 1 year after termination.* Gains and losses realized from a bona fide sale of depreciable assets within 1 year immediately following the date on which the provider terminates participation in the Medicare pro-

gram are also included in the determination of allowable cost, in accordance with the procedure specified in paragraph (f)(2) of this section. However, if several assets are sold for a lump sum sales price, the determination of fair market value must be based on the appraised value of the assets as they were last used by the provider while participating in the Medicare program.

(4) *Exchange or trade-in.* Gains or losses realized from the exchange or trade-in of depreciable assets are not included in the determination of allowable cost. When the disposition of an asset is by means of exchange or trade-in, the historical cost of the new asset is the sum of the undepreciated cost of the asset disposed of and the additional cash or other assets transferred or to be transferred to acquire the new asset. However, if the asset disposed of was acquired by the provider before its participation in the Medicare program and the sum of the undepreciated cost and the cash or other assets transferred or to be transferred exceed the list price or fair market value of the new asset, the historical cost of the new asset is limited to the lower of its list price or fair market value.

(5) *Demolition or abandonment.* (i) For purposes of this section, the term "abandonment" means the permanent retirement of an asset for any future purpose, not merely the provider's ceasing to use the asset for patient care purposes. To claim an abandonment under the Medicare program, the provider must have relinquished all rights, title, claim, and possession of the asset with the intention of never reclaiming it or resuming its ownership, possession, or enjoyment.

(ii) If losses resulting from the demolition or abandonment of depreciable assets do not exceed $5,000 within the cost-reporting period, the losses shall be allowed in the period of disposal.

(iii) If losses exceed $5,000 and, at the date of disposition, the demolished or abandoned assets are at least 80 percent depreciated as computed under the straight-line method, such losses are includible in the determination of allowable cost under the Medicare program in the period of disposal and the procedure provided in paragraph (f) (2) (iii) of this section shall be used in determining the adjustment to reimbursable cost.

(iv) Losses in excess of $5,000 resulting from the demolition or abandonment of assets, which at the date of disposition are not 80 percent depreciated as computed under the straight-line method, must be capitalized as a deferred charge and amortized as follows:

(A) If the State Health Planning and Development Agency (SHPDA) designated under Section 1521 of the Public Health Service Act approves the demolition or abandonment of a depreciable asset as being consistent with the health systems plan of the health service area in which the provider is located, the net loss realized shall be capitalized as a deferred charge and amortized over the remaining life of the demolished or abandoned asset, or at the rate of $ 5,000 per year, whichever is greater. If no State Health Planning and Development Agency exists or if such agency is unable or unwilling to perform this function, the provider shall submit a request for approval to the intermediary. The intermediary, after reviewing this request and before issuing the approval, shall submit the request along with its recommendation to the appropriate Medicare Bureau Regional Office for its approval.

(B) If a provider fails to obtain approval as specified in paragraph (f) (5) (iv) (A) of this section, a loss is not allowable unless the demolished or abandoned asset is replaced. If the asset is replaced, the loss resulting from the unapproved demolition or abandonment must be capitalized as a deferred charge and amortized over the

estimated useful life of the replacement asset at the rate of $5,000 per year, whichever is greater.

(v) If a loss resulting from the demolition or abandonment is deferred and amortized and the provider terminates its participation in the Medicare program or ceases to use a replacement asset in the provision of patient care services, the unamortized deferred charge remaining at that time shall not be included in determining allowable cost under the Medicare program.

(vi) Losses on demolition shall include the demolition cost incurred by the provider for razing and removal of the asset, less any salvage value recovered by the provider. However, where a provider demolishes a depreciable asset for the purpose of preparing land for future sale, the net demolition cost incurred by the provider (razing and removal costs less salvage recovered) shall be considered a capital expenditure and added to the historical basis of the land.

(vii) If a provider purchases land on which there is a building, no depreciation shall be allowed under the Medicare program unless the building is used in providing patient care. If the building is demolished, the entire purchase price and demolition cost shall be considered the historical cost of the land. If the building is used for patient care, but demolished within 5 years of purchase, the entire purchase price, less allowed depreciation, plus demolition cost shall be considered the historical cost of the land.

6. *Involuntary conversion.* (i) Losses resulting from the involuntary conversion of depreciable assets, such as condemnation, fire, theft, or other casualty, are generally included in the determination of allowable cost on a deferred basis if the asset is restored or replaced. However, losses resulting from a provider's imprudent management of its depreciable assets, such as the failure to obtain proper insurance coverage, are not included in the determination of allowable cost.

(ii) The net allowable loss from involuntary conversion shall consist of the undepreciated cost or unrecovered book value of the asset, less amounts received from insurance proceeds, gifts and grants received from local, State, or Federal government, or any other source as a result of the involuntary conversion.

(iii) If the asset is replaced and the net allowable loss in any cost-reporting period does not exceed 5,000, the entire amount shall be included in allowable cost in the period in which the loss is incurred. If the asset is replaced and the net allowable loss in any cost-reporting period exceeds $5,000, the loss must be capitalized as a deferred charge and amortized over the useful life of the replacement or restored asset. If a replaced or restored asset ceases to be used in the provision of patient care services or the provider terminates its participation in the Medicare program, the unamortized deferred charge remaining at that time shall not be included in determining allowable cost under the Medicare program.

(iv) If the provider fails to replace or restore an involuntarily-converted asset, the loss is not included in determining allowable cost. However, if the provider intends to replace or restore the asset but is unable to do so because the designated State Health Planning and Development Agency finds such replacement or restoration to be inconsistent with the health systems plan of the provider's health service area, the loss is allowable so long as the provider continues to participate in Medicare. In this case, the loss shall be capitalized as a deferred charge and amortized over the remaining life of the involuntarily converted asset, or at the rate of $5,000 per year, whichever is greater.

(v) If a gain is realized from an involuntary conversion of depreciable assets, the net amount realized shall reduce the basis of the restored or replacement asset. If the asset is not restored or replaced, the gain

shall be treated in accordance with paragraph (f) (2) of this section.

(7) *Effect on equity capital.* The unrecovered loss entered on the books of the provider as a deferred charge, in accordance with paragraphs (f) (5) and (f) (6) of this section, is not includable in the computation of equity capital under § 405.429.

(8) *Sale of replacement or restored assets.* If a provider sells a replacement or restored asset while participating in the Medicare program or within 1 year immediately following the date on which it terminates its participation in the Medicare program, the unrecovered loss entered on the books of the provider as a deferred charge in accordance with paragraphs (f) (5) and (6) of this section will not be included in determining the gain or loss realized from the sale of the replacement or restored asset. However, if the sale of such asset is made to a related organization, as defined in § 405.427, and the purchasing organization continues as a provider in the Medicare program, the remaining deferred charge representing the unrecovered depreciable basis of the demolished, abandoned or destroyed asset shall continue to be amortized over the remaining expected useful life of the replacement or restored asset. If the sale is made to an unrelated organization, further amortization of the deferred charge is not allowed.

(g) *Establishment of cost basis on purchase of facility as an ongoing operation.*—(1) *Assets acquired after July 1, 1966 and before August 1, 1970.* The cost basis for the assets of a facility purchased as an ongoing operation after July 1, 1966, and before August 1, 1970, shall be the lowest of:

(i) The total price paid for the facility by the purchaser, as allocated to the individual assets of the facility; or

(ii) The total fair market value of the facility at the time of the sale, as allocated to the individual assets; or

(iii) The combined fair market value of the individually identified assets at the time of the sale.

(2) *Assets acquired after July 31, 1970.* For depreciable assets acquired after July 31, 1970, in addition to the limitations specified in paragraphs (g)(1) of this section, the cost basis of the depreciable assets shall not exceed the current reproduction cost depreciated on a straightline basis over the life of the assets to the time of the sale.

(3) *Transactions other than bona fide.* If the purchaser cannot demonstrate that the sale was bona fide, in addition to the limitations specified in paragraphs (g)(1) and (2) of this section, the purchaser's cost basis shall not exceed the seller's cost basis, less accumulated depreciation.

(h) [Reserved]

(i) *Intergovernmenal transfer of facilities.* The basis for depreciation of assets transferred under appropriate legal authority from one governmental entity to another shall be as follows:

(1) The historical cost incurred by the present owner in acquiring the assets under a bona fide sale. The historical cost shall not exceed the lower of current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase or fair market value at the time of the purchase.

(2) The fair market value at the time of donation under a bona fide donation of the asset (subject to the limitations set forth under paragraph (j) of this section). An asset is considered donated when a governmental entity acquires the asset without assuming the functions for which the transferor used the asset or making any payment for it in the form of cash, property, or services.

(3) If neither subparagraph (1) or (2) of this paragraph applies, e.g., the transfer was solely to facilitate administration or to reallocate jurisdictional responsibility or the transfer constituted a taking over in whole or in part of the function of one governmental entity by another governmental entity, the basis for depreciation shall be:

(i) With respect to an asset on which the transferror has claimed depreciation under the health insurance program, the transferor's basis under the health insurance program prior to the transfer. The method of depreciation used by the transferee may be the same as that used by the transferor, or the transferee may change the method, as permitted under subparagraph (d) (2) of this section.

(ii) With respect to an asset on which the transferor has not claimed depreciation under the health insurance program, the cost incurred by the transferor in acquiring the asset (not to exceed the basis that would have been recognized had the transferor participated in the health insurance program) less depreciation calculated on the straight-line basis over the life of the asset to the time of transfer.

(j) *Basis of assets used under the program and donated to a provider.* Where an asset that has been used or depreciated under the program is donated to a provider, the basis of depreciation for the asset shall be the lesser of the fair market value or the net book value of the asset in the hands of the owner last participating in the program. The net book value of the asset is defined as the depreciable basis used under the program by the asset's last participating owner less the depreciation recognized under the program.

(k) *Limitation on Federal participation for capital expenditures.* See § 405.435, "Nonallowable costs related to certain capital expenditures" for situations where allowance for depreciation is not an allowable cost.

(1) *Transactions involving provider's capital stock.*— (1) *Acquisition of capital stock of provider.* If the capital stock of a provider is acquired, the provider's assets may not be revalued. For example, if Corporation A purchases the capital stock of Corporation B, the provider, Corporation B continues to be the provider after the purchase and Corporation A is merely the stockholder. Corporation B's assets may not be revalued.

(2) *Statutory merger.* A statutory merger is a combination of two or more corporations under the corporation laws of the State, with one of the corporations surviving. The surviving corporation acquires the assets and liabilities of the merged corporation(s) by operation of the State law. The effect of a statutory merger upon Medicare reimbursement is as follows:

(i) *Statutory merger between unrelated parties.* If the statutory merger is between two or more corporations which are unrelated (as specified in § 405.427), the assets of the merged corporation(s) acquired by the surviving corporation may be revalued in accordance with paragraph (g) of this section. If the merged corporation was a provider before the merger, then it is subject to the provisions of paragraphs (d)(3) and (f) of this section concerning recovery of accelerated depreciation and the realization of gains and losses. The basis of the assets owned by the surviving corporation are unaffected by the transaction. An example of this type of transaction is one in which Corporation A, a nonprovider, and Corporation B, the provider, are combined by a statutory merger, with Corporation A being the surviving corporation. In such a case the assets of Corporation B acquired by Corporation A may be revalued in accordance with paragraph (g) of this section.

(ii) *Statutory merger between related parties.* If the statutory merger is between two or more related corporations (as specified in § 405.427), no revaluation of assets is permitted for those assets acquired by the surviving

corporation. An example of this type of transaction is one in which Corporation A purchases the capital stock of Corporation B, the provider. Immediately after the acquisition of the capital stock of Corporation B, there is a statutory merger of Corporation B and Corporation A, with Corporation A being the surviving corporation. Under these circumstances, at the time of the merger the transaction is one between related parties and is not a basis for revaluation of the provider's assets.

(3) *Consolidation.* A consolidation is the combination of two or more corporations resulting in the creation of a new corporate entity. If at least one of the original corporations is a provider, the effect of a consolidation upon Medicare reimbursement for the provider is as follows:

(i) *Consolidation between unrelated parties.* If the consolidation is between two or more corporations which are unrelated (as specified in § 405.427), the assets of the provider corporation(s) may be revalued in accordance with paragraph (g) of this section.

(ii) *Consolidation between related parties.* If the consolidation is between two or more related corporations (as specified in § 405.427), no revaluation of provider assets is permitted.